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The Elements of Light Therapy

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The subject of light therapy today occupies a very important place in medical literature. It also occupies a very important place in the advertising sections of both medical and non-medical publications. Much has been written and much remains to be written, that may help in the proper understanding of this particular branch of treatment. The legitimate professional literature regarding it contains much that is true, some little that is untrue, and much that is largely conjectural. The advertising literature also presents much that is true, much that is conjectural, and unfortunately a very great deal that is misleading.

It is my object to describe as far as possible in a short paper some of the elementary facts concerning light therapy in such a manner that the reader may grasp certain essentials, and from these facts be able to form conclusions as to the different means of treatment, and what may be expected from such treatment.

When we speak of light we think of wave motion. We are all acquainted more or less with water waves. We have seen them and felt them. With sound waves we are less well acquainted, because our ears recognise them only as sound, and unless we study the matter we fail to recognise them as the air waves which they are. Light is still more obscure, because here we deal not with a substantial medium like water, or a less substantial though still quite palpable medium such as air, but with the invisible "luminiferous" ether, that most intangible medium which permeates all space. Light is more easily understandable if one accepts the theory that light is a form of wave motion through the ether. These waves, electro-magnetic waves as they are called, travel not with the slow speed of water waves or the sound waves of air, but with the rapid speed of about 186,000 miles per second. The waves vary in length, and each variety of wave length can be measured and its effects estimated. Just as in sound, where different frequencies of air waves produce different notes as registered by the ear, so with light different frequencies produce different colours as registered by the eye. However, the eye is limited in its capacity to visualise these colours, or bands of wave lengths, and is only able to appreciate and interpret a very few of them. That part of the spectrum seen as red, orange, yellow, green, blue, violet and indigo — the rainbow colours — are readily observed when these colours are spread out by a prism through which they have been passed as a beam of white light. The immense number of bands of wave lengths, however, which lie above and below the frequencies of visible light pass quite unnoticed by the eye and are not interpreted by us as colours, because it is beyond the power of the human eye to visualise them.

Figure 1 reveals the relation of the spectrum of visible light to the rest of the known electro-magnetic waves. The diagram is not drawn to scale, but it serves to show the relative positions of the main groups of wave lengths. The part with which we will deal is that portion of the spectrum from the infra-red region to the ultra-violet. It is these groups of wave-lengths that are used in what is generally known as light therapy.

The sun is the great natural source of radiant energy and supplies us with infra-red, visible and ultra-violet radiation. From the earliest historical times sunlight has been used in the treatment of disease and today it is the vogue in all civilised lands to consider sunlight as a panacea for the ills of mankind. Undoubtedly this new worship of the sun is being overdone, but at the same time we must realise that the race as a whole will be benefited by a more generous exposure of human skin to sunshine than has been the custom during the past.

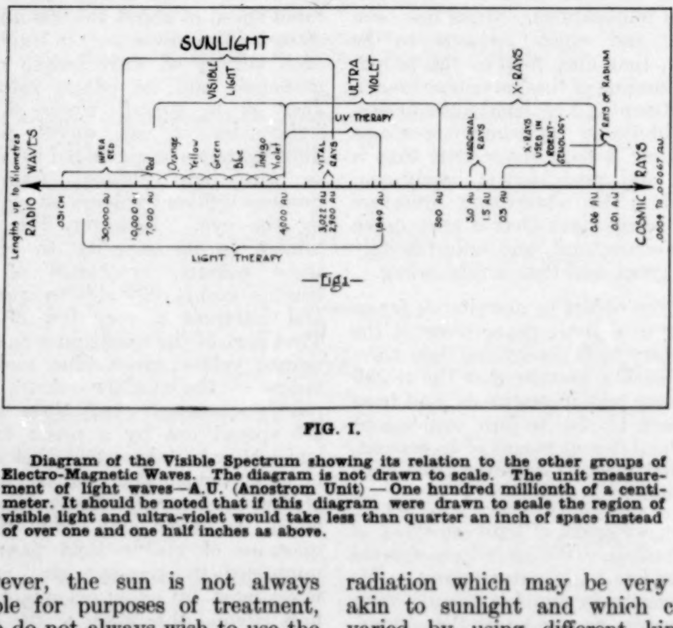
SUNLIGHT
VISIBLE LIGHT
ULTRA VIOLET
X-RAYS
UV THERAPY
γ RAYS OF RADIUM
Lengths up to Kilometres
RADIO WAVES
INFRA RED
Red
Orange
Yellow
Green
Blue
Indigo
Violet
VITAL RAYS
MARGINAL RAYS
X-RAYS USED IN ROENTGENOLOGY
COSMIC RAYS
.03 CM
30,000 AU
10,000 AU
7,000 AU
4,000 AU
3,022 AU
2,900 AU
1,849 AU
500 AU
3.0 AU
1.5 AU
.03 AU
0.06 AU
0.01 AU
.0004 TO .00067 AU
LIGHT THERAPY
—Fig1—

FIG. I.

Diagram of the Visible Spectrum showing its relation to the other groups of Electro-Magnetic Waves. The diagram is not drawn to scale. The unit measurement of light waves—A.U. (Anostrom Unit) — One hundred millionth of a centimeter. It should be noted that if this diagram were drawn to scale the region of visible light and ultra-violet would take less than quarter an inch of space instead of over one and one half inches as above.

However, the sun is not always available for purposes of treatment, and we do not always wish to use the particular combination of rays which the sun supplies. Therefore we turn to the different electrical sources of radiant energy. These artificial sources of supply are available at all times, and they also give rise to the same three different wave-length groups. However, we are able to vary the predominance of a particular group in different modalities, and so we can produce radiation which dominates in infra-red or in visible light or ultra-violet.

A further reference to Figure 1 will show that light therapy deals with radiation which commences at 1849 A.U. and continues downward through different frequencies, through the ultra-violet zone ending at 4000 A.U., the zone of visible light extending to 7000 A.U., and still further into the infra-red region until well past the 30,000 A.U. mark.

There are two types of apparatus used for producing ultra-violet radiation. They are the mercury vapour quartz lamp and the open electric arc lamp. The latter produces a type of radiation which may be very much akin to sunlight and which can be varied by using different kinds of carbons. The quartz lamp produces a radiation extremely rich in ultra-violet and extending well down to the short wave-lengths of about 1849 A.U. This radiation from the quartz lamp, while akin to sunlight, is yet quite different in that it produces a rich supply of short ultra-violet rays which are not present in sunlight.

Both of these types of lamps are useful and each has its protagonists. It has not as yet been proved, however, that one type of lamp has any advantage over the other as far as the clinical results obtained are concerned.

There is, however, this to be said about the matter. The mercury vapour lamp is the easiest, most convenient and most economical to operate It will operate on a current of between 4 and 5 amperes and produce as much ultra-violet radiation as a carbon arc lamp requiring about 100 amperes of current. For this reason it will accomplish its effect in about one-eighth the time required by the ordinary 12 to 15 ampere carbon arc lamp. This is a very important consideration when one realises that as the skin becomes accustomed to radiation and the necessary exposure time rises to about 15 minutes on each side of the body, or 30 minutes in all, using the mercury vapour lamp it would be necessary, in order to give an equivalent dose with the carbon arc lamp to lengthen the exposure time to 4 hours.

The less said about the small carbon arc lamps burning less than 10 amperes, the better. Their chief function is that of satisfying a public demand for an ultra-violet lamp for home use at a popular price. The best that can be said about them is that their intensity is so slight that little harm can result from their indiscriminate use.

Ultra-violet ray lamps give off a large proportion of infra-red rays, but at the distance of 30 to 40 inches at which the lamps are used there is very little sensation of heat. Many visible rays are also radiated, but, as with the infra-red, little heat is generated at the skin of the patient. The chief function of these lamps is, of course, to generate ultra-violet rays, and these invisible rays are radiated in large percentages. These rays produce very little heat, but they do cause certain chemical changes in the skin and produce certain effects which can be recognised clinically. The rays have very little power of penetration, the longest probably penetrating not more than one-tenth of a millimetre and the short ones being absorbed at the skin surface.

Exposure of the skin to ultra-violet rays produces a reaction on the part of the skin which shows to the eye as an erythema of slight or marked degree, depending upon the amount of exposure. This erythema is familiarly known to bathers and others as sunburn. It may be evident as a slight pinkening of the skin, a definite red, or if the exposure be prolonged vesiculation may be present. The erythema clears up in a few days, and after the damaged skin has desquamated the underlying skin either returns to its former colour or tans. A later sequela, following the tanning, is sometimes freckles. Some skins tan readily, others with difficulty.

Ordinary window glass cuts out all ultra-violet wave-lengths below about 3022 A.U., and so that group of wave-lengths lying between 3022 A.U. and 2900 A.U., which is the lower limit of sun ultra-violet, is not available when ordinary glass is interposed between the patient and the sun. It so happens that this particular group of rays is of vital necessity to animals. The young of most animals will develop rickets if they do not get enough sunshine, and experiments prove that it is the rays of this particular region of the spectrum of sunlight that are the deciding factor. On account of this, these radiations are sometimes called vital rays.

Ultra-violet light, through its action on or in the skin, produces a substance the equivalent of Vitamin D, which is found in cod liver oil, egg yolk, and whole milk. Few foods contain Vitamin D, as nature expects the animal to get this vitamin from the sunshine.

Exposure of the naked skin to sunshine or to ultra-violet light is the most reliable source of Vitamin D.

The function of Vitamin D is the control of calcium equilibrium and the regulation of mineral metabolism. It is a specific against rickets. The results of absence or deficiency are muscular weakness, instability of the nervous system, rickets, deformity of bones, carious teeth and lack of resistance against tuberculosis.

There are now available different makes of window glass which transmit these "vital rays" of sunshine very effectively. It must be remembered, however, that in order that the individuals under the glass may be benefited it is necessary that they wear thin, ultra-violet transmitting clothing, or that they expose the naked skin to the sunlight.

The shorter ultra-violet rays also produce certain metabolic effects which are not yet well known. However, it is known that these rays, particularly the ones in the neighbourhood of 2500 A.U., are very strongly bactericidal, killing practically all pathogenic organisms after an exposure of less than a minute.

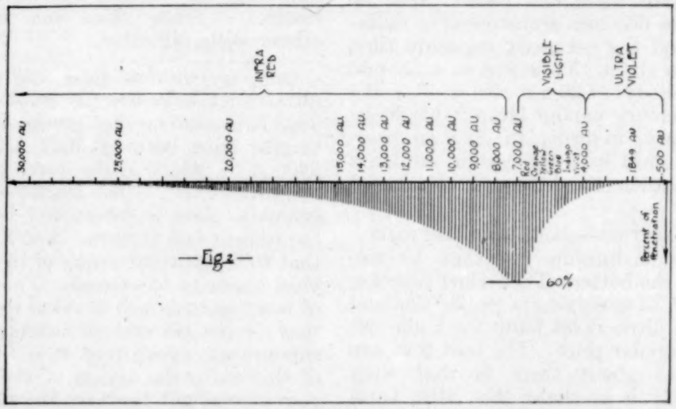

FIG. II.

Diagram showing the approximate penetration of human skin by the rays used in Light Therapy. Percent of penetration not drawn to scale. Point of maximum penetration at red equals sixty percent.

On account of the irritating effect of ultra-violet rays on the conjunctiva, it is necessary to have the patient either close the eyes tightly during treatment, or wear dark-coloured goggles. Failure to observe this precaution will result in much pain and discomfort to the patient.

Initial exposure to ultra-violet light must be of short duration, as the skin is readily affected at first. An exposure of one minute with a mercury vapour lamp at a distance of forty inches is usually sufficient to produce a mild erythema on the skin of a patient of fair complexion. Babies will sometimes react in a similar manner after an exposure of ten to fifteen seconds. The time of exposure is increased gradually as the skin becomes accustomed to the light.

Ultra-violet therapy is a specific in rickets. It is very useful in tetany. It is a decided adjunct in the treatment of tuberculosis, particularly non-pulmonary tuberculosis. Also, it is useful in pulmonary tuberculosis, when specially indicated. It should never be used in the treatment of tuberculosis of any type except under strict medical supervision. It must be remembered that tuberculosis may be aggravated by its injudicious use.

Lupus vulgaris responds very readily to treatment, and a great many other skin conditions are improved by this type of therapy. A few skin diseases, one of which is *lupus erythemtaosis*, are sometimes made worse by its use. Sluggishly healing wounds and chronic ulcers are often stimulated to heal by local treatment, and marked benefit is often obtained from general exposures where osteomyelitis, draining empyemias or other purulent conditions exist. Deep-seated pain and muscle spasm unrelieved by other measures sometimes respond to exposure to these rays, likely by reflex action, through the cutaneous nerves. Secondary anemias are often benefited, and in this connection it is worth noting that some patients with secondary anemia due to malignant conditions often feel more comfortable and have a feeling of increased vitality when under ultra-violet treatment.

During convalescence from infectious diseases and following operative conditions, marked benefit is often speedily obtained by this type of therapy. This favourable reaction is especially marked in children.

The action of ultra-violet light is essentially that of causing chemical changes in the skin. The action of visible light and infra-red, while partly chemical in nature, is mainly that of producing heat in the skin and the subcutaneous tissues. There are undoubtedly some metabolic changes induced by these particular wave groups, but these changes are not yet understood. The chief effect is that of increased circulation in the part treated, due to the action of temperature changes. In addition to this, there is a sedative effect on the nerve endings which relieves pain.

Both carbon arc and mercury vapour lamps give off a large amount of visible and infra-red radiation in addition to ultra-violet, but they are not used primarily for their heat value. Tungsten and carbon filament lamps are rich in the visible and near infra-red fields. The tungsten filament lamp known as the blue daylight bulb delivers a spectrum dominant of about 9,000 to 10,000 A.U. The usefulness of this particular lamp in treatment, where it is proposed to introduce heat deep in the tissues, will be readily recognised if one refers to Figure 2, which shows that the greatest penetration of the rays lies between about 5,000 to 10,000 A.U. The blue daylight bulb more nearly meets these requirements than any other generator.

The non-luminous or infra-red generators contain dark bodies treated by electrical resistance to a point just below that at which they would glow, or which glow a dull red and deliver a spectrum which is dominant of 30,000 A.U. and below. A further reference to Figure 2 will show that at this point there is very little penetration of the human skin. Therefore, with this type of generator most of the heat is formed on rather than under the skin, and any heat which reaches the subcutaneous parts is conveyed there by conduction Where deep treating effects are desired, and such is generally the case, radiation with the blue daylight bulb mentioned is the method of choice. A method sometimes employed for getting a greater concentration of light rays in the deep tissues is to place the radiant generator so close to the skin that under ordinary circumstances a heat burn would result An electric fan is then allowed to play on the part thus cooling the skin surface, and preventing untoward effects, and yet not effecting the more intense heating effect of the subcutaneous tissues, a consequence of the increased local radiation. Radiant heat generators should be properly focused to avoid heat spotting and consequent small blisters on the skin.

Radiant heat is used for the relief of pain in lumbago, myalgia, neuralgia, etc., and is often of marked value. It often gives relief in acute inflammation of the accessory nasal sinuses. It is a useful preliminary to massage. It is valuable as a means of stimulating the skin and sweat glands, and is often used in connection with hydrotherapeutic measures. Radiant heat may be said to be useful in any superficial condition which may be benefited by an improved circulation.

In conclusion, it may be said that both ultra-violet and radiant heat are very useful forms of treatment. They are not, however, cure-alls, and they should be considered along with other physical therapy measures only as adjuncts to general medical and surgical procedures.

Editorials

Voluntary Enrolment of Registered Nurses

Eventually the time has arrived when registered nurses of Canada are to be given an opportunity of voluntarily enrolling for service in war or disaster.

For several years a joint committee of the Canadian Red Cross Society and the Canadian Nurses Association has been engaged in developing a plan for a national enrolment of nurses. The proposed enrolment in its very beginning was endorsed by the Director-General of Medical Services of the Department of National Defence, who has agreed that in the event of war use will be made of the register of enrolled nurses.

This register will be kept at the national headquarters of the Canadian Red Cross Society. The enrolment will be made through the provincial associations of nurses and the provincial Red Cross Societies. Only registered nurses recommended by the provincial associations of nurses will be enrolled.

Canada has been fortunately free from disasters for some years but that does not ensure that this fortunate state of affairs will continue. Canadian nurses and those interested in the activities of the Canadian Red Cross realise that Canada must have a nursing service ready for action should an emergency arise.

As has been stated already, the enrolment is entirely voluntary on the part of the nurse and, while the act of enrolment means that a nurse is ready to respond to calls for service, there are a number of conditions which shall receive consideration by the joint committee of the society and the association before a nurse is called up for service. These are:

1. The responsibilities of the position she is holding.
2. The urgency and importance of the work upon which she is engaged.
3. The type of work for which she is best fitted.
4. The nature of the service required.

It is expected that the provincial associations will co-operate to make the enrolment a real success. In fact, this should be made the major activity of the organisations for the coming year. After it is well started, it will become a routine procedure.

Pin Money versus Education

Another school of nursing, one in connection with one of Canada's largest hospitals, has recently announced that after 1932 the sum of money now being used for students' small monthly allowances will be used to secure a more adequate ward teaching staff. The subject has been under consideration by the Board of Trustees, the Training School Committee, the staff and students of the school for some time and a decision has just recently been reached. A small allowance counts for very little but intelligent teaching extends through life; one might even state that the benefits of such teaching may reach beyond the individual and into the coming generations.

Sometimes one wonders if graduate nurses as a whole fully recognise the amount of time and deliberation that is given by those active in the teaching of nursing; even when constantly alert to efforts put forth and results gradually achieved, there is a possibility that one fails to grasp all that is being done.

The older nurses should remember that it is astonishing how much good can come from former graduates being interested in the development of their Alma Mater and its reputation. In fact there is a powerful influence always existing among graduates and on them rests the responsibility of assisting greatly in the acceptance of new ideas and institutions as the old order changeth.

Health Work in the County of Warwickshire

By M. E. MISNER, R.R.C., F.B.C.N.

The thought of that very pleasant and delightful week in one of the best settings that England can produce will live with me as long as my memory lasts. For a Canadian to step off the train on the 26th day of March and find herself in the heart of spring, to walk through the lanes leading from the station to the hotel and see pear trees in bloom, crocuses peeping and daffodils blowing, and hear the spring birds singing! It was joy! And this was Shakespeare's country, and the old, old shire town of Warwick, where the hospital, the great castle and most of the houses date back to Elizabeth's time and beyond. Warwick Castle is the best preserved of its kind and time, and is still used as a residence; while Kenilworth Castle, a few miles away, built at the same period, is one of the most interesting of ruins, since it belonged to the Earl of Leicester, who, being a great favourite of Queen Elizabeth's, entertained her there. There are so many interesting stories about these places and so many wonderful things to see, which the ordinary traveller revels in, but few have the chance to study the inner modern workings of these historic places, as far as health work and sanitation are concerned, at least. The stories of the absolute *lack* of sanitation of Elizabeth's time are glaring and repulsive indeed, compared with the great work being attempted, and the great strides made, towards a perfect health programme in that County at the present time.

This report deals only with the country section of the County, including villages and towns up to 10,000 population and has nothing to do with the Boroughs of Nuneaton, Leamington Spa, Sutton Coldfield and lately, of Coventry.

The area of the County is 550,851 acres, inclusive of the boroughs, but only 502,411 rural. The population is 370,600.

The County Medical Officer of Health is A. Hamilton Wood, M.D., D.P.H., under whom there are five assistant medical officers of health, who also act as school medical officers. Three of them also assist with sewage inspection, one takes the ante-natal work at three centres and one at one centre. There are whole time medical officers devoting three-quarters of their time to school medical inspection. One lady medical officer devotes one-half her time to medical inspection of secondary schools and the medical officer of health for the borough and rural district of Stratford-on-Avon rather less than half his time to the same, giving a total strength of just over three whole-time inspectors of school medical work. Two women doctors do high-school girls and the men do the boys. In elementary schools the women do all the work. There are four part-time doctors as well.

The dental staff consists of two whole-time, one half-time and one part-time dental officers.

The County Health Visiting Staff consists of a superintendent, and fifteen health visitors, each devoting one-third of her time to school nursing and dividing the rest of her time between maternity, child-welfare, generalised public health, tuberculosis, orthopedics, etc.

The health visitors inspect all midwives four times a year as routine but make many other visits to them for special purposes. Miss Lowe, however, is superintendent and trainer of these women and of school, tuberculosis, clinic nurses and infant visitors.

There are 38,500 school children in 307 schools, the average for each nurse being 7,700 pupils, which is equivalent to whole-time service of five school nurses or part-time services to 2,500 children by 15 nurses.

Throughout the County are dotted little dispensaries, seven in number, served by the medical staff of the joint committees of the County of Warwick and Coventry. At Coventry is an X-ray and other equipment where the Chief Tuberculosis Officer takes charge and where all county cases may be sent, if thought necessary. Otherwise the three assistants deal with them at the small centres. Tuberculosis notices are sent by local medical officers to the Chief Medical Officer through the office of the Superintendent of Nurses. As soon as she receives the notice, Miss Lowe notifies the health visitor of the district where the case occurs. After the health visitor has visited the patient and given instructions on the proper way to live and has left hand-bills of instruction as well, she fills out and sends a report form to the Chief Tuberculosis Officer, so that he will know the case when the patient comes to the dispensary. At Sutton Coldfield there is a sanatorium of 191 beds, there being accommodation for twenty-nine incipient cases and thirty-five hospital beds kept free for those suffering from non-pulmonary tuberculosis. The tuberculosis dispensaries are held once a week, at least, and often twice a week.

Sanocrysin, a gold-containing substance, has been extensively used on the Continent in the treatment of tuberculosis but tried experimentally in England only the last four years. During the six months' period, fifty patients were treated at Coventry with this substance. Twenty-two showed definite improvement, five were found unsuitable subjects and treatment was discontinued. Six showed no improvement, three became worse and six died. If the improvement shown by the twenty-two cases continues and lasts it should be concluded that sanocrysin is beneficial in a certain number of cases but years must elapse before final results can be judged with accuracy.

In the County there are thirty-four Voluntary Infant Welfare Centres and two new ones are seeking the approval of the Ministry of Health. Whilst open, these centres are attended by a county health visitor, who acts as supervisor, thereby insuring uniformity of management and co-ordination of the work of the Voluntary Committee. In some few instances a district nurse midwife conducts a centre, a county health visitor paying a visit monthly for purposes of supervision. The attendance of mothers and infants at these centres has been respectively 22,750 and 28,014 in the year. The registers show an enrollment of 1,829 mothers and 1,243 infants under twelve months of age. A complete system of health records is kept in all dispensaries, clinics, centres, schools etc. The County Council supplies envelopes, and postage, so that a child's records follow him from clinic to clinic, from clinic to school, etc., from infancy to the end of school life.

Warwickshire holds the pioneer position in the institution of the Health Visiting system and has been the model on which many other countries have since developed their health visiting service. Miss Mildred Lowe, a highly trained woman in all matters relating to healthy living, who had spent 17 years of study, research and experience in France, came back to her native county in 1902 and after looking about, approached Professor Bostock Hill, the then Medical Officer of Health in Warwickshire, with the suggestion that the County needed health supervising such as could only be supplied by a nurse. She was taken before the County Council to explain her ideas. The Council was sceptical but finally said that they would engage her for one year and if at the end of that time she could show as a result of her work, a reduction in maternal mortality, they would continue the work. The salary offered was exceedingly small, and no grant given for transportation, but the following year she secured a bicycle and started out.

Midwives up to this time were untrained and had things pretty much their own way in rural districts. Miss Lowe handled these old dears so deftly that before long she had them wearing a regulation dress and bonnet, carrying uniform and adequate equipment in baskets and beginning to take a pride in themselves and their insignias of office. By appealing to their vanity and self-esteem she had them before long convinced of her argument, that whichever midwife had the largest number of successful cases to her account, and the largest number of breast fed babies and the smallest number of maternal and infant deaths, attending her ministrations, would be the one most likely to gain registration, which was sure to come soon and which it would be a great honour to have. Since midwives were very poorly paid, they could not afford elaborate equipment, but Miss Lowe insisted on it at least being adequate and kept absolutely sanitary, as far as they understood the word. Watches were out of the question, so little one-minute sand-glasses were secured and distributed as a fairly accurate record of the pulse-rate could be kept. These little instruments were enclosed in nickel tubes, open at two sides and supplied with a ring at one end so that they could be worn suspended from the neck or tucked into the breast pocket. That was the beginning of the inspection of midwives, and gradually the health visiting work grew. Schools were visited tentatively but the health visitor's calls were after a time looked forward to. By the end of the year there was no disputing the fact that fewer deaths had occurred in childbirth and without a doubt the midwives were doing better work—taking pride rather than showing resentment in having someone interested in the bettering of their conditions and giving them more status. Miss Lowe found a great friend and a strong ally in Professor Bostock Hill and they worked in happy co-operation for many years. Miss Lowe's work was strenuous and difficult. Prejudice, suspicions and ingratitude all reared their ugly heads. Her rides by bicycle were often long and sometimes fruitless but she held her vision dear and kept steadily on. In the week I spent with her I learned to love her very much. I could see what a glowing light she must have been shining down this long twenty-five year road. Others of necessity have seen it too, and last year her name was included among the King's Birthday Honours, as a Member of the Order of the British Empire. At the annual meeting of the County Federation of Infant Welfare Centres last year, the splendid work for mothers and babies which had resulted from the long partnership of Miss Lowe and Dr. Hill was publicly recognised. A scheme was announced to mark the occasion and to honour the work she has done and is still doing for the Welfare Centres of the County. A handsome bronze challenge shield to be known as the "Mildred Lowe Shield" was shown and is being presented for competition amongst the Infant Welfare Centres. Professor Hill, speaking at the meeting, said that those who knew Warwickshire before the beginning of this century and know it now as regards the conditions of health existing in the homes of the people, would say that in the manifest improvement lies the most important and valuable memorial to Miss Lowe, though the shield afforded something concrete which the eye could see.

Dr. Wood, the present County Medical Officer of Health and Miss Lowe, took me to Stratford-on-Avon, one afternoon, where the doctor was speaking to midwives, health visitors and district nurses, at the Infant Welfare Centre on the "Still-Birth Registration Act of 1926". The definition for the terms "Still-Birth," "Abortion," "Miscarriage" and "Premature" were carefully gone over. Some of the midwives were worried as to whether they were keeping the new law or not, as by it, it is compulsory to have registered all "still-births." Also they were pleading that midwives working in remote rural districts be subsidised by the County Council since cases were scattered and few in comparison with those presenting themselves to midwives of towns and cities. There is already some system of subsidising doctors in some places and it has been known for midwives. In Warwickshire 1,000 medical helps at five shillings per visit during pre-natal, pregnancy and lying-in periods, and for babies and mothers are provided per annum. This was first started in 1918. In spite of this medical help, however, the maternal death average remains fairly constant—the death rate in 1902 being 3.5 per 1000 and for 1927 was 2.3. Every third or fourth year brings a rise in the percentage and every third or fourth year brings a lowering. It was pointed out by Dr. Wood that Warwickshire maternal death rate of 3.3% for 1928 and the infant mortality of 54 to 1000 births compared favourably with the rates reported for the whole of England and Wales. He says that it has been proven that only 5% of still-births are due to syphilis. In any case of unduly large, flabby placenta weighing one-quarter the weight of the foetus at birth, the mother should have a blood-test and prompt treatment for syphilis. "The lack of ante-natal care," he said, "is to blame for the high maternal death-rate. Educating the doctor while he is still a student at university, in the supreme importance of ante-natal care would not only lessen the maternal mortality but the infant mortality also, as 85% of all head injuries could be prevented with proper and efficient ante-natal care *and treatment.*" "At a recent meeting in London," he continued, "a plan was advocated by which pressure would be brought to bear to cause all prospective mothers to attend ante-natal clinics, the pressure suggested to be the withholding of maternity benefits from all women who cannot produce evidence that they have attended such clinics."

Miss Lowe and I traversed the County by train, bus, tram and taxi each in turn. A very interesting day was spent at Rugby. Here the Health Centre is a prospering and paying place, as it has a Maternity Home in connection. Orthopedic, minor ailment, ante-natal infant welfare, post natal and dental clinics are also conducted here. At Warwick the same type of Centre is working—only it has an eye clinic as well. A very pretty garden is kept at both places. Miss Lowe has her residence at "The Butts" (the Warwick Centre). The economic feature of these centres is that the Maternity Home and rooms for all the clinics mentioned, besides the apartments of the Supervisor of Health Visitors, are all included in one rent. At Rugby we took time at noon-hour to look in at the sports at the famous Rugby Grammar School. In peering into the class-rooms of this school of grand tradition we found that the very same forms and desks which were put in when the school was built are still being used in exactly the same way and in the same rooms.

At Bedworth mining town a very lively Health Centre exists. The committee here bought an old army hut, had it cut in two crosswise, had the two halves set side by side and took out the two adjoining walls, making one large, almost square room. Partitions were put across the front for ante-rooms and across the back to form a kitchen on one side and a doctor's examining room on the other. Lately a large pram shed has been erected at the back to accommodate the numerous infantile vehicles, because a usual day at the clinic has 96 babies present with as many mothers. The marvelous response of the mothers and prospective mothers of England to the appeal of the benefit derived from the Welfare Centres and Clinics is amazing. Not only in Warwickshire, but throughout the whole country wherever these Centres exist.

Communicable Disease and the General Hospital

By F. W. JACKSON, M.D., D.P.H., Director, Division of Communicable Diseases for Manitoba.

A very cursory glance through the available statistics in reference to disease and deaths in Manitoba, impresses on one's mind the tremendous amount of sickness and loss of life in our population through communicable disease. When we consider that about one out of every sixty of our people suffer each year from infectious disease, and that contagious disease accounts for 14 per cent. of our total deaths, we can readily see that the subject of communicable disease is well worth serious consideration by any group of individuals interested in the health of the people in the various communities throughout the province.

The subject matter of this paper might be divided into two parts: the first being "Hospital Care instead of Home Care for Communicable Disease."

Today at noon there were 114 cases of communicable disease, exclusive of tuberculosis, outside of Winnipeg, requiring treatment in the province of Manitoba. Of this number, we find only five cases under treatment at the various general hospitals which are attempting to provide isolation facilities for communicable disease. It is generally considered that a community, for its own protection, is responsible for the care and treatment of its cases of communicable disease. A hospital is a part of a community, so it would seem reasonable to suppose that a general hospital in a community, where no other provision is made, should at least feel some responsibility for the treatment of cases of infectious disease.

In larger cities, the matter of caring for infectious disease, is a well recognised civic service. Usually adequate isolation facilities are maintained and operated as a civic enterprise and directly under the control of the local health authorities. In smaller cities, towns and rural areas, however, the situation is entirely different. Very few, if any, communities outside of the cities of Winnipeg, St. Boniface and Brandon give the matter of isolation facilities for their communicable disease any serious amount of thought. Of the eighteen general hospitals in the province, outside of Greater Winnipeg, only five have any isolation facilities. That is why I have taken the opportunity of trying to bring the matter of proper isolation of communicable diseases to the attention of those who are responsible for the hospitalisation of sick people, particularly outside of the city of Winnipeg.

A study of any one of the communicable diseases, from the standpoint of care and treatment, is very enlightening. Take diphtheria, for instance; during 1928 there were 972 cases with 58 deaths reported in the province. This gives a case fatality rate of 6.0. In the city of Winnipeg there were 605 cases with 23 deaths, or a case fatality rate of 3.8. In the rest of the province there were 367 cases with 35 deaths, or a case fatality rate of 9.8. Why this great difference between the case fatality rate in Winnipeg and the rest of the province? The only reasons I can see are that in Greater Winnipeg nearly 80 per cent. of the cases of diphtheria occurring, were treated in hospital, while in the rest of the province less than 20 per cent. were so treated; and that isolation hospitals have

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(Address given before the Manitoba Hospital Association and Manitoba Graduate Nurses Association, September, 1929.)

better facilities for the treatment of communicable disease.

Looking at it in another way, we find that of these 972 cases, 665 were treated in the various isolation hospitals in the province. This group of cases accounted for 25 deaths or a case fatality rate of 3.8. Amongst the other 307 cases, which were treated at home, there were 33 deaths, or a case fatality rate of 10.8. If all the diphtheria cases in the province last year had been treated in hospital and had received the same efficient treatment that those who were treated in hospital received, there would have been at least a saving of 24 lives. This would indicate that there is a decided advantage, certainly in the case of diphtheria, to have treatment of our communicable diseases provided in special hospitals for the purpose.

The economic loss due to this method of handling communicable diseases in the rural part of Manitoba, must be considerable, besides which there is the disadvantage of the possibility of improper isolation with the resultant spread of disease in and out of the household, to say nothing of the possibility of the patients themselves having less efficient treatment. Also it would appear that in the city, a great deal of the anxiety caused by communicable disease in the home is removed by the removal of the patient to the isolation hospital.

If each section of the province had at its disposal some hospital, or part of some hospital, which was responsible for the care of communicable cases, especially those due to diphtheria, scarlet fever, smallpox and typhoid, a great deal of the disadvantage of our present method of trying to prevent the spread of communicable diseases would be removed.

On whom, then, should the duty of making provision for the hospital care of this type of patient devolve. Primarily, the financial burden of looking after these cases rests with the community or its governing body, namely, the town, village or rural council. At present, under the "Health Act," the governing body of any district in which communicable disease exists, is responsible for the isolation, quarantine and other things necessary to prevent the spread of infection. In the case of indigent patients, it is the usual custom for the council to be held responsible for their medical care also. The financial expense required, therefore, for the establishment of such isolation quarters for communicable disease, should be the direct responsibility of municipal organisations in the province. However, it would be absolutely prohibitive financially for every rural village or municipality to build, outfit and maintain such quarters as are required for the care and isolation of infectious diseases. Rather would it seem that it would be more logical to expect that such quarters should be built as a part of the general hospitals now located throughout the province, which would eliminate a duplication of the staff, equipment, etc. Certainly from the standpoint of preventing the spread of communicable disease, the matter should be given consideration by the general hospitals located throughout the rural areas of Manitoba. You may well say that supposing we have facilities for isolation cases, they will not be used. At the present time, possibly this is so, but I would venture to point out that the same thing was said in regard to the Civic Infectious Disease Hospitals when they were first started in the city of Winnipeg. It is entirely a matter of education, not only of the public but of the general practising physician — education not only to point out the possible financial saving, but also to point out the possibility of obtaining more efficient treatment of this type of case, thus reducing the needless waste of life from these diseases.

The second point for discussion is the prevention of the spread of communicable disease within the general hospitals. Certainly an epidemiologist should not have the nerve to attempt to outline technique or other things pertaining to hospital management, especially when these are common practice today for the prevention of the spread of infection. Rather should he discuss one or two things which seem to him of the most vital importance to prevent the occurrence of those very regrettable accidents which sometimes happen through ordinary medical, surgical and obstetrical cases contracting communicable disease while patients in general hospitals.

It would seem essential that one of the first requirements of those seeking employment in hospitals as nurse, ward maid, kitchen help or orderly, should be that those applying for such situations should be Schick and Dick negative. The usual method now, I believe, is to hire the individual first, and then proceed to determine whether such individual is Schick and Dick negative. In a great many cases, even this much is not done, especially in so far as making inquiries and tests to ascertain whether the individual is susceptible or not to scarlet fever.

A great many cases are reported year by year of the personnel in general hospitals communicating infectious diseases to the patients under their charge. Probably one of the most outstanding of these is one that occurred in a general hospital in England from January, 1921, to May, 1923, where it was definitely proved that a ward maid had given some 33 persons scarlet fever, 22 of these being patients in the hospital, six being nurses, one a ward maid, and four individuals in private homes. This might easily occur anywhere in the province, under the general system now employed. It would seem, then, that if employees in hospitals are engaged without one of the requirements being that they are immune to scarlet fever and diphtheria, every effort should be made after they are engaged, to see that they are made Schick and Dick negative.

In so far as making an individual immune to diphtheria is concerned, it is now a comparatively simple and absolutely safe procedure and the immunity given by the use of toxoid is permanent, in so far as we know at present, in at least 90 per cent. of persons so immunised. In a study of 57,000 school children who were Schick negative in the city of New York, Park states that over a period of five years he has only in five instances seen a clinical diagnosis of diphtheria made amongst these children; whereas fifty cases occurred among 90,000 other children who were not known to be Schick negative. Among 10.000 children under observation in the Williard Parker Infectious Disease Hospital in New York, no case of diphtheria has ever developed amongst those giving a negative Schick, while out of 300 other cases treated in the same hospital giving a positive Schick, 42 cases of diphtheria developed. All evidence now available, points to the fact that diphtheria could be almost entirely eliminated, if toxoid administration could be made universal.

In so far as scarlet fever is concerned, the Dicks of Chicago claim and with some degree of proof, that the same holds true. In Central Europe where active immunisation against scarlet fever has received a great deal of attention, many reports of the procedure have been published—many enthusiastic and some saying that it is not of much value. One of the most reliable, however, gives us the following information: In 21,955 persons, ages 1-18, who were actively immunised, there were 94 cases of scarlet fever, an attack rate of .43, while in 89,918 non-immunised persons, 1,558 cases developed, or an attack rate of 1.26. So non-immunised individuals are three times more likely to contract the disease than those who are immunised. It is also stated from the same source that a positive Dick Test is quite reliable, but that in an individual who shows a negative Dick, the test should be repeated.

Certainly amongst the employees in hospitals, the matter of immunisation against scarlet fever is well worth considering and should at least be given a fair trial. The usual method followed in well organised hospitals at present, is that a nurse about to be employed on a scarlet fever ward, is given a prophylactic dose of scarlet fever antitoxin. This gives, as we know, a passive immunity for from 10 days to two weeks. Active immunisation is started within two days after the nurse has received the prophylactic antitoxin. This is continued until she has received altogether 5-6 doses of the immunising agent. By this method, it is claimed that 75 per cent. of persons so treated become Dick negative for a period variously estimated, of from 2-10 years.

I think a better plan to follow would be to Dick Test all persons engaged in hospitals and to immediately start active immunisation of those who were found to be Dick positive, giving altogether five doses of the toxin. After a period of 10 days, the Dick Test should be repeated and if still positive, one more dose of one c.c. containing 10,000 skin test doses, given. Again repeat the Dick Test and if required give another dose of the same size. If 10 doses in all are required to obtain a negative Dick, it should not be too much trouble to obtain an immunity to scarlet fever.

In my own experience, immunising children has been of real service. Some five years ago, I was asked by a certain consolidated school board to suggest a means of ridding their district of scarlet fever. It had been prevalent in the district for years and every winter some of the children would go down with it. The school children were all Dick tested and the 48 showing positive Dicks were given a course of immunisations. During the time since then, no case of scarlet fever has occurred in that district.

Measles, whooping cough, mumps and chickenpox still present a problem and until such time as we know more about the causative agents of these diseases, not much can be done towards preventing those engaged in hospitals from becoming a possible source of infection to hospital patients.

To summarise then, it would seem that the ordinary general hospital, in respect to communicable disease, has two duties in a community:

First: To assist in the provision of adequate facilities for the isolation and care of communicable disease, and,

Second: To take all measures now available to prevent the possibility of any spread of infectious disease among hospital cases through the agency of hospital help or nursing service.

The Travelling Dietitian

By ALICE C. LANGLEY, Travelling Dietetian for Saskatchewan

The proper selection and preparation of food, both in health and disease, is today occupying the attention of our people in a manner that was not dreamed of even a decade ago, and the dietitian is now being recognised as an important factor both in hospital work and in all institutions where the human family congregate. The Government of Saskatchewan, realising the growing importance of this work appointed in the spring of

1928 a travelling dietitian to be attached to the Department of Public Health.

For the first year the work was confined to the Union Municipal Hospitals, which vary in size from twelve to fifty beds. These hospitals are not training schools, neither have they a resident dietitian. The nursing staff is composed of graduates. Most of these young women have had a dietary course and diet kitchen experience during their training. The kitchen staff of these small hospitals, having had little or no experience of hospital cooking or diets prior to their employment in the hospital, made it necessary to give the administrative side of the work paramount importance. Dr. Middleton, the Deputy Minister, advised the necessity of a refresher course of lectures for the nurses, so the plan followed in this work was to deal with the administrative side in the kitchen and with the theoretical and instructive side with the nursing staff.

Primarily the travelling dietitian co-operates with the matron and through her with the kitchen and nursing staff. For the period of a visit which is usually two weeks, the dietitian takes control of the kitchen, and for the first few days it is necessary to proceed slowly. The staff must be studied so that one may approach them without antagonising, and the first day or two are spent in observation and in offering suggestions. Then, if the cook is responsible for the ordering, a menu is suggested and it is left to her to carry out. During the second week the dietitian tries, if possible, to arrange the menus herself, and have them prepared and cooked along dietetic lines. She usually has the hearty co-operation of the cook, who by this time has learned that any criticism offered is not destructive but constructive. It is impossible to carry out the same hard and fast dietetic principles in the small country hospital as can be done in the hospital situated in the larger centres where there is variety and abundance of supplies to work with. Here one must use what can be procured. In many of the hospitals it was found that pork, cabbage and turnips formed part of the diet for staff and patients alike—especially in the winter time, and whilst all these articles may be included in the staff dietary, an endeavour has been made to impress upon the cook the inadvisability of serving them to the patients, explaining the reasons for not doing so. Frequently one is agreeably surprised by the dietetic knowledge displayed by some of the cooks and their desire to prepare food best adapted to the invalid dietary.

A series of ten lectures is held in the evenings; the first four are theoretical and are a review of: 1. The composition of the body and the composition of food showing the relation of one to the other. 2. The chemical and mechanical digestion of food. 3. The fuel value of food and a comparison of food values. 4. How to calculate the calories required for basal metabolism and for bodily activity. Following these, lectures are given which are a combination of lecture and practical demonstration, when the dietitian prepares and serves six or seven recipes each evening arranging them in the following order —1. Beverages. 2. Milk. 3. Eggs. 4. Cereals. 5. Desserts. 6. Meats. Each nurse attending the lectures receives a typed sheet of all recipes demonstrated.

This year the writer included in her itinerary a small training school where she spent a period of two months lecturing to the student nurses and teaching the third year students in the Special Diet Kitchen, where they prepared the food for the special diets. They also made soups, broths, beef-tea, custards, jellies and desserts for all the patients up to, and including the light diet and for the latter they cooked chicken, the lighter vegetables and light cakes.

Department of Nursing Education

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Ward Teaching

By MARTHA BATSON, Teaching Department, Montreal General Hospital

This is a wide subject which might be dealt with from many aspects. As only a limited period of time is available, I shall confine my remarks to one or two methods of developing "Ward Teaching" on general wards—as medical and surgical. We are beginning to realise more than ever that the most successful method of instructing student nurses is at the bedside of the patient. Why? Because there she is brought to a more direct experience of situations. She learns the real needs of the sick from actual contact with the patient. Many opportunities arise to apply her class-room teaching to concrete situations in life. The ward should be the chief demonstration room for the instruction of nurses.

Ward teaching may be developed—

First—By the assignment of patients, which Miss Harmer has outlined so completely in her book Methods and Principles of Teaching the Principles and Practice of Nursing, and which reads as follows. "Three or four patients are assigned to each student nurse, the number depending upon their condition, and the student's experience, ability and opportunity to give them adequate care. The student is made entirely responsible for the patients. Such treatment required by the patients, if not already learned, should be taught by the ward supervisor as the need arises. The length of time a patient will be assigned to any one student demands very careful thought, both from the standpoint of the patient and the educational needs of the student. It is important that every effort be made to assign the patients, and to regulate the student's hours of assignment, to give her a rich and varied experience. This careful planning and teaching are only possible when the head nurse knows how long she may expect the students to remain with her." (This plan has recently been adopted in our hospital.) "Much stress should be laid on the responsibility of the student. When a task is assigned to her, she must be made to feel that she, and she only, is responsible for its perfect performance. Mistakes will occur, but these mistakes while not desirable, are in themselves an important part of teaching. The student should be encouraged to work from the class room to the ward. Careful supervision is absolutely essential, otherwise wrong habits may be acquired, and the work of the class room entirely undone."

Second—The Case Study Method—This method was first introduced into Schools of Nursing by Sister Domatilla, of St. Mary's Hospital, Rochester, Minnesota. This method of teaching has many advantages. It develops the student's observation, and tests her capacity to collect important information concerning her patient, which she has obtained from

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various sources. It stimulates the student's interest, and gives her a better understanding of her patient, which will ensure intelligent nursing care.

The instructor or ward supervisor should guide the student in the selection of the patient she wishes to study, and should provide her with information from time to time, also instruct her to record daily, on the form provided, the symptoms, medication, special nursing care, laboratory findings and complications. On completion a short conference is arranged, and the student is questioned on the important phases of the study. This enables her to get a certain amount of individual instruction.

We have adopted the Case Study Programme Card, which Miss Jensen has illustrated in her book on Case Studies, and on this card is entered "the diagnosis of the case studied—and the student's rating." Case Studies should be introduced at the beginning of the intermediate year, in conjunction with medical and surgical lectures and classes, and should be continued, if possible, until the student has completed her training.

Third—Ward Clinics—In dealing with this subject, I shall briefly explain the plan adopted in our school of giving a series of Ward Clinics to junior nurses. Just before completing their first year, the students go to the class room for two weeks intensive study. During this period the advanced Nursing Procedures and Principles are given. In conjunction with these, six ward clinics are arranged. By securing the co-operation of the ward supervisors, and the internes, on the general wards, many of the advanced procedures may be demonstrated at the bedside. For instance, a few days ago, the class room lesson was on "The Hot Pack". The principles preceded the demonstration. At the time a patient in one of the medical wards suffering from acute nephritis was receiving this treatment. The following day the students were taken to the ward, where the interne on that particular service gave a bedside clinic on "Acute Nephritis," emphasizing the signs and symptoms and reasons for giving the treatment. Two ward nurses then gave the pack. The students were then requested to prepare a paper on "Acute Nephritis" and bring to class the following day. This is an ideal method of teaching. The nurse who has seen a case of morphine poisoning, will remember it long after it has been forgotten by the nurse who only heard it talked about.

As one realises the importance of ward teaching, the question arises, how can it be successfully developed, and who should be responsible for its development?

The graduate head nurse (who is always ready to co-operate and in most cases willing to teach), on account of the modern rush of work and the burden of ward administration finds it impossible to do it in a systematic way.

Special ward teaching can only be successfully developed by the appointment of specially prepared supervisors. Supervisors whose special duty would be to teach and supervise nurses at the bedside of the patient.

Miss Cox-Davies in her paper on Co-operation between Ward Sisters and Sister Tutors, read at a round table during the Congress, International Council of Nurses, said: "Every case on the ward should be explained to the student nurse, and she should attend clinical rounds. It is the Ward Sister's prerogative to teach her, and to explain the condition of the patient—details should be supplied also, so that knowledge could be passed on."

Ward Teaching—Discussion

By EILEEN C. FLANAGAN, Royal Victoria Hospital, Montreal

We all know that "assigning a student to duty on a ward does not necessarily guarantee an education for her in that kind of work," and we also know, as some one has aptly remarked, "that just as there is never a convenient time to admit a patient, so there is never a convenient time to add ward teaching to the curriculum," and, therefore, it would seem that the opportune time must be the present time.

It is generally agreed, that before the need of class room instruction was fully recognised, that there was considerable teaching done on the wards; and then owing to the stressing of class room teaching in order to focus its need, ward teaching was perhaps relegated to a second place.

This was accentuated by the addition of full time class room instructors, and the head nurses began to feel their responsibility in teaching less. Now we feel that a balance must be maintained between these two types of teaching if we are to get the results we should have.

As the ways and means of teaching on general wards have been discussed, I shall deal only with special services. In a special service it is a much easier matter to plan and carry out a definite schedule of teaching. In the first place the nurse in charge will usually be an expert in her particular field, more apt to be very enthusiastic about her work and in keeping up with all the latest developments in it. The wards are smaller as a rule, and the doctor in charge a specialist, and closely interested in every detail of his department. Authority will be centralised and a well thought out system of routine ward procedures carried on. The nurses coming to these wards are the more senior ones, and should not require a great deal of supervision in routine nursing care, therefore giving the nurse in charge an opportunity of concentrating on the special teaching needed. A good plan is to have posted in a prominent place, or in a book kept for the purpose an outline of what the student should expect to learn while caring for these particular patients. This means not only the various technical procedures, but also the attitudes, ideals and understandings necessary to give the patients the best nursing care. This gives the student at the outset the feeling of fitting into a definite place, of realising that she has a certain role to play, and that some tangible results are going to be expected from her before she leaves. If it is possible to add but one new student each week it gives the head nurse the opportunity of giving considerable individual instruction, and as they are usually of the same seniority it is the best plan to have them rotate according to length of time on the ward, and this makes it comparatively easy to have a definite system of assignments. In a pediatric ward, for example, the new student on the ward is taken by the head nurse and shown the entire ward; has each child's condition explained, isolation technique demonstrated, and is shown the programme of her stay there. Then she is given the older children to care for during the first week. The second week the nurse in charge demonstrates the bathing of infants to her and she is given the infants to look after. The third week infant feedings are taught and the nurse assists in making them. The fourth and fifth weeks, if on day duty, the student is taught the special charting, makes rounds with the staff, and takes the clinics. If on night duty the last two weeks, this work has to be given in the earlier weeks. During their stay in the ward each student makes a case study of one patient, if necessary following the case after having left the ward, until the time of discharge. The ideal arrangement of course is to have the class room instruction in pediatrics proceeding at the same time, but this is not always possible.

Again, the students gain a great deal if they can attend the out patient clinics in pediatrics while on the ward. In a metabolism department, which has its patients segregated, much the same method of teaching can be carried out. In this case the regular instruction programme of the diabetics, for instance, can be utilised for the student nurses, for while they are learning themselves, they are also learning how to teach the patients and to get fully into their minds the needs and difficulties of their patients. They have the opportunity of preparing the special diets and of learning to know the individual patients at the same time. Here, perhaps, is as good an example as any of the correlation of theory and ward practice for the students are able to attend all the clinics given on the ward on the theory and treatment of diabetics, and by attending the out-patient clinics once a week they get an insight into the social service aspect of the disease. Many students have said that the reason they liked these departments was because of the definite planning of the work, and the close relationship between them and the patients.

In obstetrics there is a unique opportunity for ward teaching, and in this field, it may be stated, more systematic teaching has been done than perhaps in other services. To quote a recent writer: "In ward teaching certainly the head nurse has the vantage point existing nowhere else, by creating the proper atmosphere on the ward, she imbues the student with zeal and healthy attitudes towards her work; by correlating social, medical and nursing information and treatment, she teaches the student that her patient is a member of a group with family, church and social ties which are an integral part of his being, and which may be used to hasten his recovery." When we realise as some one has put it, "the good results that have been obtained here and there with some good individual ward teaching, but what great success might be obtained if all those who can, would concentrate on the proceedings taking place where the students work with their patients, the most interesting, strategic and vital centre of the whole institution—the ward "

The Student Nurse's Health

By MABEL K. HOLT, Superintendent of Nurses, Montreal General Hospital.

Among the many responsibilities assumed by the head of a training school for nurses, none is more arduous nor causes greater anxiety than the care and maintenance of the student nurses' health.

We are all accustomed to the usual forms to be filled out by the applicant when desiring to enter the hospital training school. Alas! we are also very much aware of the futility of many of these so-called physical examinations. With this firmly imprinted on our minds, we feel that our own checking up of the students' fitness for her chosen profession cannot commence too soon. Therefore, within a day or two of entering the hospital, the students' feet receive our first attention. The chief of our orthopaedic service most willingly gives his valuable time to inspect the odd fifty pairs of feet, in order to determine at the outset what type of shoe should be worn by each individual student, therefore, they are warned not to buy their shoes until after this examination. The uniform of the school calls for black oxfords, but the make depends entirely on the individual's feet and which the doctor considers necessary for comfort and correct position. In a school of over two hundred students a very small percentage suffers from painful feet, and where this occurs it has usually been traced to infected tonsils, which on removal creates a normal condition.

Our attention is next turned to vaccine. As each student is required to bring on entrance a certificate of vaccination for small-pox, it is typhoid inoculation that now takes place. After serious consideration we do not feel justified in view of the small percentage of cases both of scarlet fever and diphtheria that occur amongst our pupil nurses, to give the serum indicated for these communicable diseases. At the affiliated hospital where this experience is taken a prophylactic dose is given in each case, before the nurse enters the wards treating the particular disease.

Between the second and third month a thorough physical examination is made of each student by the medical superintendent. Previous to this examination x-ray of the chest is made, and the reports dictated by the roentgenologist or his assistant are typed and sent in to the training school office. All recommendations for further treatment or examinations are noted and attended to from this office. I feel very strongly that if a recommendation has been made for removal of tonsils—then a tonsillectomy should be performed at the earliest date possible. Neglect of this only adds to our troubles and increases the days lost due to colds, sore throats and often painful joints.

To those who will read this short article it seems quite unnecessary to point out the importance of good housing for the nurses. We are all aware of this, and those of us who are fortunate enough to possess modern residences with single, well ventilated bedrooms, plenty of bathroom facilities, spacious well-lighted class rooms, realise how much this has affected for good the health of the nurse in training.

Sports and recreation of all kinds should be provided and encouraged. Physical education given to the probationers throughout the first four months, is always taken in the open air when weather permits. Finally I would like to add that nurses are requested and indeed encouraged to report all illness or infection at once. Sometimes one wonders if this encourages malingerers. On the other hand I deprecate very much any severe handling when a nurse reports sick. How much better to be too careful than to make some dreadful mistake! In any case, when the indisposition occurs frequently the nurse can be asked to resign on the grounds of ill health, as not being strong enough for the life of a nurse. It is our custom to handle an illness through the training school office. A sick room is provided in one of the private wards, with accommodation for ten nurses. It is seldom we require more beds, our percentage this past winter being four per cent. and even less. A nurse is placed in whatever service suits her condition and a preference for any one doctor is respected.

A valuable legacy has been left for the use of the nurses in training when ill. It is left entirely to the judgment of the superintendent of nurses how that money should be used and by whom. Therefore special nurses can be employed when necessary, and convalescence in the country paid for—when the nurse is too far from her own home.

(Contributed by the Section on Administration of Schools of Nursing, Alumnae of the School for Graduate Nurses, McGill University.)

Department of Private Duty Nursing

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Neurological Factors in the Home

By ROBERT G. ARMOUR, M.B., Attending Physician, Toronto General Hospital.

The following is the substance of a talk which I gave to the Community Health Association a few weeks ago. It consists of observations made of all types of cases that nurses are likely to encounter, which observations I have made since being asked to give this talk. Naturally, it will, therefore, be somewhat disjointed.

With regard to the disease, chorea, a point of considerable importance which I should like to emphasize is the emotional disturbance, which may take place weeks or even months ahead of the choreiform movements. The child who previously had been obedient, good-tempered and of average intelligence, is found at the school or in the home to become irritable, wayward and stupid, and the interpretation of this may not be made until more or less permanent damage has been done to the child's character. Such diagnosis might be suggested and investigated where an observation of this character is made. The next point with regard to chorea is the importance of tonsillectomy. Tonsils cannot be safely removed during the acute stage of chorea, nor while the tonsils show any active infection. The ideal time for their removal is when the child seems so well that the parents are unwilling to upset him. For this reason, repeated opportunities for a successful tonsillectomy are missed, and when the tonsils are eventually removed, the desired result, that is, freedom from successive attacks of chorea, is not achieved. I am of the opinion that secondary foci of infection have been established in the cervical glands or the mediastinal glands. Much might be done by the visiting nurse in urging early attention to nose and throat troubles in these cases.

What I have said about these emotional disturbances brings me to make a statement that can be applied to almost all forms of chronic disease. I spoke of the character being permanently affected. All forms of chronic disease, and most particularly nervous diseases, produce a certain emotional disturbance. This has possibilities of forming habits of thought of a very undesirable or distressing nature, which may proceed throughout life and may be the basis of even such serious results as some of the major psychoses.

The next disease which occurs to me is acute anterior poliomyelitis or infantile paralysis. We have seen a great deal of it recently in Ontario, but we may even yet have to face an epidemic of the above mentioned such as existed in the Western Provinces. I would like to emphasize an early sign that I do not think is properly appreciated, and that is, practically an invariable occurrence of vomiting and diarrhoea, or both, from three to ten days before the onset of paralysis. It seems to me that those cases should have had this condition vigorously treated by a prompt and effectual remedy such as castor oil. If done, lesser paralyses and less permanent ones may result than in those who have had these gastro-intestinal disturbances neglected. There need be no dispute about the diagnosis because the treatment would be the same where infantile paralysis is threatened or where it is a simple vomiting or diarrhoea of the summer months. If, however, pain is experienced in the limbs or any stiffness of the neck or back, I would feel that the diagnosis is almost certain.

The next disease which occurs to me to speak about is that "so-called" epilepsy. I say "so-called" because we know such conditions as uraemia, eclampsia and so on, which can cause convulsions, and we know that constipation and other digestive disorders in children can produce convulsions. Therefore, it does not seem reasonable to take all other cases of convulsions, not so easily explained, and simply group them together under the name of epilepsy. Every case of convulsion should be investigated for the cause of the convulsions and we do not need to argue about the name of the disease. My personal feeling is that certain individuals have what might be called a convulsive potentiality, that is, under certain circumstances they will have convulsions while the average individual will not. But the individual convulsion in these cases is most usually precipitated by influences entirely outside of the nervous system. Even in the adult this may come from the gastro-intestinal tract or any other form of peripheral irritation, and among different forms of peripheral irritation I would like to mention with considerable emphasis ordinary physical fatigue or mental fatigue, as induced by worry and pressure of activity. One of the tragedies that has grown up about these cases on account of the use of the word epilepsy, has been the stigma applied to such cases. Many have said that such cases go insane. I may say that the actual proportion that develop elipeptic dementia is almost negligible as compared with those suffering from convulsions who have just as good mentalities as anybody else in the world. But when one sees these cases excluded from schools, denied vocational training and discharged from their positions on the occurrence of the first convulsion, as so often happens, one is not surprised that changes in their dispositions and mentality develop which are then wrongfully ascribed to their disease. It is just as essential that these people should be given education, employment and recreation if they are to be healthy minded as the more fortunate individuals.

Next, I should like to speak of cases of coma, merely to mention a danger that attends all such cases when being looked after by unskilled attendants or relatives. These patients have a tendency to roll over on their backs and lie day in and day out in this position. Such cases are much more likely to develop bed sores, to have moisture collect at the base of the lungs, resulting in hypostatic pneumonia, or to develop cystitis or more serious genito-urinary infections than if they are rolled from side to side at least a dozen times a day. This is a point that the visiting nurse might very well watch for and give instructions to the family. This condition naturally brings to mind hemiplegia, and another danger threatens the patient. The limb which lies or hangs immobile may very easily develop adhesions in the joints or contractures of the muscles, and so when the neurological lesion is recovered from we find a limb incapacitated from purely mechanical conditions which might easily have been prevented. These cases should have the helpless limbs moved at all their joints throughout the full excursion of such joints at least twice a day, and a simple kneading massage should be applied to all muscles. This does not need a professional masseuse, but can be carried out by the family after very simple instructions.

We come then to another form of paralysis, the "so-called" flaccid paralysis, in which the muscles lie flabby , and through accident or from the natural position of the limbs these muscles often become stretched. For example, the deltoid which is stretched by the arms hanging down, the extensor muscles of the knee joint which are stretched whenever the patient sits with the knee bent, and the muscles of the shin which are stretched by the weight of the foot in walking or by the weight of the bed clothes. It can be laid down as an absolute rule that a stretched muscle can never recover from paralysis. Very little observation and reflection will suggest how such stretching may occur and this should be prevented by splinting or some other form of mechanical appliance. It is to be remembered that one night of stretching of such muscle by the bed clothes or by faulty posture after removal of splint may undo the good of weeks of careful splinting.

It had been my intention to say something to you about functional nervous disturbances, but the subject is so vast that I should not care to do more than call your attention to a few points. One of these points is our tendency to reproach the case suffering from such a condition and to accuse him or her of merely trying to excite sympathy, as if this was the motive for the complaints. This shows an entire misconception of the basic principles of functional nervous diseases. The patient experiences unpleasant symptoms and quite naturally thinks that a disease exists. The patient has not the technical knowledge to know whether this is organic or functional, but sincerely believes that he is ill. Under these circumstances, it is perfectly natural and quite legitimate to expect sympathy. I do not mean to say that sympathy will do such a patient good. Frequently, much more good may be done by reassurance, but one must be careful not to appear to belittle the suffering of such a patient nor to be in any degree deriding him. Much has been said of modern civilisation, and of the rush and competition which this involves as a cause of functional nervous disease. This may be so in certain cases where the strength is over-taxed, but an extremely important influence must not be overlooked, and that is, the stupidity and monotony of many households. Women are perhaps particularly exposed to these influences. During the child-bearing age they have little oportunity for cultivating interests outside of their household cares, and it is a difficult thing at forty-odd years of age to begin this habit. Again, these very household cares involve a considerable degree of monotony unless the individual is endowed with unusual enterprise and initiative. As the children grow up and go to work or leave home, these women, at a critical period of their life, are left alone much of the time without sufficient interest to employ their minds. It is a great chance for them to think too much, and not having developed outside interests to think about, they turn to introspection and to their own apprehensive interpretation of physical discomforts and domestic unpleasantness, with the formation of what I have spoken of above, namely, habits of thought that may have serious consequences. The visiting nurse can surely do much throughout the whole of the lives of their patients and families to stimulate the cultivation of interests and the practice of a reasonable amount of legitimate recreation.

HOW TO TAKE THE "LUG" OUT OF "LUGGAGE"

A lot of girls seem to have the idea that they can enjoy themselves better travelling in foreign countries in two's or four's than in a party. If they are all experienced travellers, perhaps they can, but for "first-time" travel there is nothing like a congenial, well-managed, personally conducted tour. You are constantly with your friends if you wish to be, you have no worries over language difficulties, customs, foreign money, unscrupulous guides and couriers. You travel free of luggage and free of care—nothing to do but enjoy yourself—and with your trip planned for you by experts, who know how to arrange the maximum sightseeing with the minimum of discomfort; who know how to handle hotel managers; what to do in emergencies, and generally how to make life a very pleasant and happy thing. All this if you join the right party: and for information on this, see the advertisement for the FIFTH ALL-CANADIAN TOURS to Europe.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section, Miss MARY MILLMAN, Department of Health, Toronto, Ont.

County and District Health Units in Canada

By EDNA L. MOORE, Assistant Director, National Organisation for Public Health Nursing, U.S.A.

The legislative ramifications of public health in Canada began with the Quarantine Act of 1794 and passed through numerous changes as the necessity arose to control cholera, typhus, plague or smallpox. After Confederation the provinces assumed responsibility for the well-being of their people, leaving to the Dominion Government matters that might affect the whole country. The "Act respecting the Department of Health, 1919," established a Department of Health with a Minister at its head. This Act also provided for the Dominion Council of Health, an advisory body made up of the executive officers of the provinces and five others who represent agriculture, labour, education, and the interests of both rural and urban women, under the chairmanship of the Deputy Minister. This Council meets twice a year. In 1928 the Department of Health became the Department of Pensions and National Health.①

County or district health units represent the centralisation of health administration, on a full-time basis, in a number of parishes, townships or municipalities, according to the province in which they are established. They also represent a decentralisation of the provincial administration.

Since legislation and administration vary throughout the provinces, the points that seem pertinent to our subject will be discussed as we meet them *en route* from the Atlantic to the Pacific.

PRINCE EDWARD ISLAND

Prince Edward Island, with its three counties, has a population of 85,000. In 1927 the Public Health Act was amended considerably, and within the past year the first full-time provincial health officer was appointed. The Maritime Tuberculosis Educational Committee urged this step and contributes to the budget. Plans to build a sanatorium are under way. The entire province is a disease-free area for cattle.

Public health nursing was organised five or more years ago by the Canadian Red Cross through its Prince Edward Island Division. Increasing appropriations have been voted by the Government for this service. The staff now numbers five, including the chief nurse, and there are two district centres. As yet no provision has been made for a morbidity service.

It is more probable that organisation will continue to develop on the present basis than that county units will receive attention for some time to come.

NOVA SCOTIA

In Nova Scotia the Department of Public Health is the central organisation. The health activities of the parishes, towns and cities, with notably few exceptions, are carried on by part-time medical health officers. In several counties public health nurses are doing yeoman service in which they receive assistance and advice from the Division of Public Health Nursing.

The Nova Scotia Tuberculosis Commission co-operates with the provincial authorities in providing a travelling diagnostic clinic. All sections are visited. Two public health nurses are assigned to do follow-up work and co-ordinate the activities where a county or Victorian Order of Nurses' service is established.

As yet no legislation has been introduced to permit the counties to organise full-time units.

NEW BRUNSWICK

To New Brunswick belongs the honour of appointing, in 1918, the first Minister of Health within the Empire.

The province is divided into four health districts and a full-time medical officer is in charge of each. The districts are large and the lack of adequate public health nursing service hinders the development of the work. Yet each year finds more communities conscious of the need and making efforts to supply it.

There are no part-time medical health officers in the province, although health offices are maintained locally with registrars and sanitary inspectors.

The Department provides a diagnostic service, assisted by the Maritime Tuberculosis Educational Committee.

For school medical service there are six districts, each being in charge of a full-time medical officer. In several centres school nurses are developing splendid programmes, financed by local Boards of Education, of the Victorian Order of Nurses, and service clubs, with assistance from the Department of Health through its Division of Public Health Nursing.

With such advancement in full-time service it is to be expected that New Brunswick will continue to increase her public health nursing personnel rather than to seek a sub-division of her districts into county units.

QUEBEC

The Provincial Bureau of Health administers health organisation in Quebec. A full-time medical health officer representing the central authority is in charge of each of the eighteen large districts. In the parishes the part-time medical health officer is largely the rule. Twenty-one Tuberculosis and Child Welfare Dispensaries have been established by the Bureau. These centres are uniformly equipped and one or more public health nurses are attached to each.

In 1925 the Bureau director made a survey of county health units in the United States. The outcome was a recommendation to his Minister that a similar system adapted to local needs and conditions be set up in a few counties as a demonstration. This plan received favourable consideration and history alone will reveal its full significance.

In Beauce County, at Beauceville, on February 1, 1926, the first county health unit in Canada was opened under the direction of the Provincial Bureau of Health.

Beauce, with a population of 46,000, is an entirely rural county, with a few villages of 2,000 or 3,000 people. It is situated in a delightful part of picturesque old Quebec, about fifty miles south and west from Quebec City.

The offices of the unit are well equipped. A complete set of records is in use and an x-ray plant has been installed.

The budget is $12,000. One-half is contributed by the Provincial Government and the other half is to be raised by the local municipalities through a health tax. For the first years the International Health Division of the Rockefeller Foundation will provide a part of the municipalities' share on an annually decreasing scale.

The personnel consists of a full-time medical officer, two public health nurses, a sanitary inspector and a secretary, who in addition to routine office work collects from the clergy birth, marriage and death certificates, makes copies of them and sends the originals to the Division of Vital Statistics in Quebec.

Transportation in summer is by motor (the nurses buy their own cars and receive a monthly allowance for upkeep), and in winter by train and sleigh.

The school was chosen as the point of attack. From there the news spread rapidly. Soon the entire neighbourhood knew much about "l'infermière visiteuse," what kind of uniform she wore, the make of car she drove, and best of all what she said about clean hands, toothbrushes, food and sleep, and, event of events, the doctor was coming to school. Acute communicable disease, tuberculosis, pre-school, prenatal and post-natal work are being developed. Close co-operation is maintained with religious and educational authorities. When the writer visited Beauceville the medical officer and one of the nurses were returning from a morning visit to a neighbouring district, where they had each addressed a meeting. It was the Forty Hours' Devotion, and the curé had arranged for these health talks after the morning service, thus giving weight to the message which reached every home in the community.

With work planned for the week, each nurse leaves the Centre on Monday morning and goes to a parish, where she continues her work until Friday evening. Saturday mornings are devoted to record-keeping and staff meeting, where reports of the week are given, situations discussed, and plans for the following week submitted to the medical officer for approval.

During the summer, when harvesting is at its height, home visiting is suspended except in emergencies and the records for the year are compiled. A report of school conditions found, improvements made, and further recommendations is prepared, and copies are sent to the Provincial Bureau of Health, the Provincial Department of Education, the local Board of School Trustees, and the curé of each parish.

The carefully kept records reveal much that is inspiring. Such entries as "windows in three walls," "window in blackboard," "no water supply," "water in open bucket," "common drinking cup," "no washing facilities," all too frequent in 1926 and 1927, were giving place in 1928 and 1929 to the improvements suggested by the medical officer in his report.

Beauce County Health Unit was the first; Quebec now has twelve. In the beginning the professional staff was sent to Ohio for a period of observation and study. With the rapid development of the unit system it has been found desirable to establish a training centre in Beauce County.

Excepting the larger towns in a few of the counties where Victorian Order Nurses or Metropolitan Life Insurance nurses are established, there is no morbidity service.

In Temiscouata County the unit centre is located in the hospital.

Each year a conference is called by the Director of the Provincial Bureau, when the personnel of the units and the Tuberculosis and Child Hygiene Dispensaries meet to discuss their problems.

The general acceptance of the unit system is reflected in the action of the Legislature in 1928, when an Act was passed ratifying the procedure and providing for its continuance and further development.

ONTARIO

In Ontario the Department of Health is charged with the administration of health activities. Through the services of eight full-time district medical health officers, a staff of public health nurses, a travelling tuberculosis clinic, a school medical staff, sanitary inspectors, subsidised venereal disease clinics, industrial hygiene, health education and dental departments, this work is carried on in co-operation with the full-time units in the larger cities and the part-time practising physicians who serve the greater part of the province as health officers. Many smaller cities and towns have established public health nursing service largely through the efforts of the Division of Child Hygiene and Public Health Nursing. As yet no legislation has been introduced to permit counties to organise health units.

MANITOBA

Last year in Manitoba permissive legislation was enacted and provision made in the budget for the establishment of full-time health units. Three areas are under consideration and educational work is being directed toward securing the vote of the local municipalities for maintenance of a portion of the cost. The difficulty of such a promotional effort can only be appreciated when it is borne in mind that a population of 10,000 may be scattered over a large territory and involve a number of municipal councils. Meanwhile the Division of Public Health Nursing and the Department of Health carries on extensive health service through its staff of thirty-five or more nurses.

SASKATCHEWAN

In 1928 and 1929 the Legislature of Saskatchewan passed amendments to the Public Health Act of 1909, providing for the establishment of full-time health units. Such units are to consist of eight rural municipalities and the towns of 10,000 population or under within their boundaries. The staff is that outlined as a standard unit by the International Health Board of the Rockefeller Foundation: a duly qualified medical practitioner, one or more public health nurses, one or more sanitary inspectors and a secretary-technician.

For some time the Department of Health through the staff of the Division of Public Health Nursing has been paving the way for health units. The Union Hospitals, the Red Cross Nursing Out-posts, the Anti-Tuberculosis League, the plan for subsidising doctors' salaries in some communities and the entire payment of the salary in others, have all contributed to the formation of favourable public opinion.

One health unit is in operation in the southern part of the province, with headquarters at Gravelbourg. The area is 2,592 square miles, the population 23,093, the budget $14,000, of which $7,000 will be paid by the district, making the rate about 35 cents per capita. As in Quebec, the Rockefeller Foundation is participating in the financing of this unit for three years on a gradually decreasing basis.

The staff of this unit received scholarships to study similar work in the United States and also to visit urban organisations in Eastern Canada.

It is estimated that twenty-five such units would serve the province adequately.

ALBERTA

In the spring of 1929 the Alberta Legislature passed an amendment to the Public Health Act authorising the establishment of district health units. Educational efforts have been directed toward the crystallisation of public opinion in the more promising communities. During the summer and fall, 1929, two special surveys were conducted by the Public Health Nursing Branch. Much pioneering work has been done throughout the province, and not the least of this centres about the municipal hospitals. Doubtless Alberta is rapidly approaching the time when the results of these efforts may be measured by the yardstick of district health units.

BRITISH COLUMBIA

British Columbia has four full-time health units in addition to the two large cities where Departments of Health have been established for some time. The first unit, and the only one visited by the writer, comprises the municipality of Saanich, adjoining the city of Victoria. The population is about 15,000, the area 55 square miles, the budget $16,000, and the location one of the most beautiful in the country.

The other units have smaller budgets and serve fewer people.

The Rockefeller Foundation is participating in the financing on the same basis as in Quebec and Saskatchewan. wan.

Space will permit but a brief reference to one of the interesting developments in public health in British Columbia. The Education Act provides for the payment of $580.00 from the provincial treasury toward the salary of every school teacher in rural districts. This Act was amended to include public health nurses and dentists. Thus official recognition was given to one of the fundamental principles of public health nursing, namely: every public health nurse must be a teacher.

The Saanich Unit staff consists of a medical officer, four public health nurses, a sanitary inspector and a clerk. The Unit Centre is a rather large building erected by the community as a memorial to the men who gave their lives in the Great War. The first floor is used for administrative offices, clinic rooms, and other activities, while the nurses have living quarters on the second floor.

A generalised nursing programme is carried out, in which the morbidity service case load consumes a relatively large proportion of the nurses' time. Acute communicable disease work has been a "best seller." In 1926, the year before the unit was organised, the municipality paid for hospitalised cases $6,200.00. In 1928 this item claimed but $100.00 from the budget.

Under the Provincial Board of Health a diagnostic chest service is furnished through a travelling clinic. A portable x-ray outfit as well as the salary and travelling expenses of a public health nurse are contributed by the Tranquille Tuberculosis Society, from the Christmas Seal Sale Fund.

The Department of Nursing of the University of British Columbia works in close co-operation with the Board of Health. Students receive their rural field experience at the Saanich Unit and an annual refresher course is conducted at the university.

THE NURSE.

The place of the public health nurse in county and district units is our chief interest. Since she is the vanguard of organised health and social work it follows that she must be conversant with community resources and traditions, and equipped to apply the fundamental principles of public health nursing. It is her privilege to bring people to an altruistic attitude toward quarantine, to convince the ignorant parent that his crippled child need not necessarily remain so because "he was born that way," to observe the kitchen garden (or lack of one) and therefrom deduce a nutritional programme which by her adroitness will become effective with the family. These things and many others she will do as she carries out her school, pre-school, tuberculosis, maternity and child hygiene, mental and social hygiene programme. Moreover, she must keep step with the developments in the educational field, never failing to secure sufficient recreation to maintain her health and bring enthusiasm to her work. In as much as she meets these problems and helps to solve many of them the "happiness content" of her job will be great and will attract those of adventurous spirit and philosophic mind, provided that sufficient professional and community support is accorded.

It is earnestly hoped that, in the two provinces where greatest headway has been made in unit organisation, the nurses who are attempting such important pioneering work may soon have the guidance and encouragement of an advisory nursing service.

In support of this suggestion the following is quoted: "Whatever be the form of nursing adopted, whether generalised or specialised, and whether supported by official or voluntary contributions, or both, it is considered essential to the highest efficiency that all nursing work of the Department of Health should be organised in a separate bureau and under the direction of a chief who is herself a nurse."②

(①Canadian Public Health Journal, March, 1929—Dr. J. W. S. McCullough.)

(②Community Health Organisation, page 42. Edited by Ira V. Hiscock, assistant professor of Public Health, Yale School of Medicine. Published by American Health Congress Series, 1926.)

The term "morbidity service" in the foregoing article is used according to the definition of this term as prepared by the National Organisation of Public Health Nursing and published in The Public Health Nurse, October, 1929, i.e.: "Morbidity service, which is often called bedside nursing, is concerned primarily with the care of sick persons under or pending medical direction, but it also includes as an extension of its work with cases of communicable disease the supervision of persons who are suspected of having, or who are known to have been exposed to, a communicable disease. The nursing is not limited to sick persons confined to their beds, but is given to ambulatory patients as well. The care is not only actual nursing, but includes instructions as to health habits, nutrition, and other factors bearing on the general health of the individual nursed. It may also include needed service during the period of convalescence."

Miss Edna Moore, formerly field nurse for the Canadian Tuberculosis Association, joined the National Organisation of Public Health Nursing staff in October, 1929.—Editor's note.

Child Welfare

By BLANCH EMERSON, Edmonton

When in a rash moment I consented to submit before this Convention an article dealing with certain phases of Child Welfare, I expected to be addressing groups of nurses other than those of our own section. Since this is not possible, I feel that much of what I shall say will not be new to you, although it may serve to refresh your memories and revive your interest in the Care and Feeding of the Infant and Pre-school Child.

The more we come into contact with children in the early days of their lives, the clearer it becomes to us that a greater stress must be laid on prenatal work in order to obtain the best results in our work. This is possibly our most difficult task.

The expectant mother hesitates to talk to others about her condition and absolutely revolts at the idea of attending a prenatal clinic where she may meet other women she knows. The older and more experienced prenatal case has consistently been found to develop a still more independent attitude towards offers of clinical help or advice during this very important period, and in many cases the result of her indifference works to the detriment of both mother and child. This is not a local condition but one that exists in every Public Health Centre. The mother and the public must be educated to the need for prenatal care. They cannot be forced.

Records show that the most successful results have been achieved at the Prenatal Clinic of the New York Maternity Centre where the parents are very poor and are obliged to report early in their pregnancy or they cannot receive free nursing and medical service during their confinement.

We do, however, come in contact with many prenatal cases in their homes and we offer to place them on our prenatal list. We send in their name and address, date of last menstruation, and date of expected labour to the Provincial Department of Health which in turn sends out a monthly prenatal letter in which are stressed numerous important points. These letters are excellent, and are greatly appreciated by those interested who very often pass them on to friends.

It is customary for us to visit these prenatal cases. We insist upon making an early visit to the family home, giving advice on diet, fresh air and exercise, hours to rest, etc. We also tell them of the danger of having fresh paint around during this time.

For example: In regard to the diet we urge them to use milk and milk products, cereal, leafy vegetables, and to eat only a limited amount of meat and those foods unsuited for bone and teeth building, for the diet of the prenatal case has a definite bearing on the structure of the child's teeth.

We are also able to advise our prenatal cases to have proper care during confinement. If they are to be confined at home and have not engaged a graduate nurse, we urge them to call the Victorian Order Nurse.

The next step in the Child Welfare Programme is to have every baby breast fed if possible. This is also included in prenatal teaching. This sounds like a very simple matter. Hasn't the student nurse said in the examination paper in answer to the question "Why is breast milk the best for babies?" "Breast milk is best because it is never sour and always ready." However, you would be surprised as to the number of mothers who do not nurse their babies. A few because they are unable to do so, others because the importance of doing so has not been pointed out to them, and others in whom lactation does not develop through lack of care during the first few days after confinement. In one of our local hospitals the junior nurses are known to ask the mothers if they would rather

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(Read at the annual meeting, 1929, of the Alberta Association of Registered Nurses.)

nurse their babies or put them on the bottle. In the same institution the babies are not taken to the mothers at night but are given a bottle of condensed milk. In many cases the mother thinks her child sleeps all night. She leaves the hospital with a very good impression of it but is annoyed when she reaches home to find the baby does awake at night and is not satisfied with breast milk. Dire results follow, in nine cases out of ten the baby weans himself from the breast before he is a month old. I am quoting these statements from our own files over a period of years. There is a great need for student nurses to be taught more about the importance of breast feeding.

A larger percentage of babies in the country are breast fed than in the city. Modern housing conditions and the wear and tear of city life are large factors in causing this situation.

For those mothers whom we find with a limited supply of breast milk we advise the following routine care:

1. Extra fluid, chiefly water, hot or cold. One glass upon nursing and one before or at each of baby's feeding time. The nursing mother should take at least 1½ pints of water during the day.

2. The diet should be plain, wholesome and nutritious. The mother should take three hearty meals a day with nothing in between meals. Cornmeal porridge taken as cereal is is exceptionally good for increasing the flow of milk.

3. The bowels should be well regulated, the patient should have plenty of rest, outdoor exercise and baths.

Local treatment of breasts advised: bathe breast first with hot and then cold water, dry quickly with a rough towel stroking from the base of breast towards the nipple. Rub gently ten to fifteen minutes. Put baby at both breasts with absolute regularity.

After each nursing express the milk between thumb and finger until the breast is empty. If the supply is still not sufficient advise giving one ounce of barley water, or milk one ounce, water one ounce in a bottle, after each feeding. This amount is increased as required.

In cases where a breast fed baby is obstinately constipated, barley water one ounce given as directed will supply the bulk needed and control the situation.

It should not be necessary at this late date to have to insist or to even give reasons why babies should not be fed on condensed milk, but we find doctors and nurses still advising mothers to use it. It is easily prepared, the child likes it and grows fat and also very pale, dentition is delayed, and 95% of babies so fed show evidence of rickets.

Condensed milk is composed of milk solids 29%, water 28%, cane sugar 43%, so it is a very questionable substitute for fresh milk. It has its own use in certain types of infants who require a high carbohydrate diet. These are rare cases and should be under a child specialist's care

Evaporated milk is just milk with three-fifths of the water removed but the temperature at which it has to be heated in order to evaporate it (200cc) spoils it for baby's use. Certain powdered milks do not share in this disadvantage, because the drying is accomplished at a lower temperature, so that by adding water the same properties are maintained as in fresh milk with the exception that there may be lacking a newly suspected vitamin known as X, which is believed to be found in the water part of the milk. This can be supplied by giving orange or vegetable juices.

When mother's milk fails there is no substitute that equals cow's milk. It is rendered very digestible by boiling for three minutes over direct heat. We usually measure the quantity of water required and when boiling we add the milk, stir for three minutes, remove from heat and add sugar. The babies are fed by weight. Their weight is multiplied by one half ounce which gives the amount of milk required in twenty-four hours. All babies weighing under ten pounds require one ounce of sugar, those over, one and a half ounces. By adding this to the age of the baby in months the amount required at each feeding is estimated.

All bottle fed babies should have orange or tomato juice daily and cod liver oil from early fall to late spring. Even breast fed babies thrive better if given cod liver oil during the winter months.

Then last, but not in any sense of the word least, are the home conditions. It is through the contacts with the home that we can put forth our best efforts to each individual child. The confidence of the mother is gained, advice is given for routine care. The household arrangement is looked over and we are better able to understand the mother's problem in the rearing of her child. I am reminded of the school card that said "Mary very pale and under-nourished, advised Mary to drink milk. Mary says she will." Now, that may give the nurse a great sense of relief, but how can she know whether Mary's mother will provide the milk unless she knows her and her home conditions.

Rural Work

We try to reach as many rural children as possible through our travelling Child Welfare Clinics. We are rarely able to visit each town yearly but the interest is stimulated by even a single visit as the mother can then write in for advice and this is worth something to the mother and growing child. These clinics are sponsored by the various women's organisations and it is gratifying to note that each organisation has a convener of Child Welfare who is very active in putting the Child Welfare Work over. In many places the value of milk in the diet has been made a subject to study and much good is being accomplished.

NOTES FROM ICELAND

The following information and announcements have been received from the Secretary, International Council of Nurses.

In commemoration of the granting on June 19th, 1915, of women's suffrage in Iceland, the Icelandic women founded a fund for the building of a state hospital which is to provide complete education for the medical profession in Iceland as well as for nurses and midwives. The fund has been generously subscribed to and has also been subsidised by the Government, and the hospital will be ready for use in 1930, the year of the millennial festivities. Hitherto the Icelandic nurses have taken part of their training in the various hospitals in Iceland, and the rest has been taken in Denmark and Norway, as Icelandic hospitals have not offered sufficient practicalexperience. The Icelandic Nurses Association has been advising on all the arrangements with regard to the nursing service of the new State Hospital, and has had some difficulty in getting a three years' course accepted, several of the more prominent citizens feeling that Iceland could not afford to provide more than two years' training for its nurses.

Nurses who may be visiting Iceland on the occasion of the celebration of the Thousandth Anniversary of the foundation of the Parliament of Iceland will be welcomed by the Icelandic Nurses Association, which will be glad to assist them in every way to make their stay there as interesting as possible.

Please write to Mrs. Sigridur Thorvaldsson, President of the Icelandic Nurses Association, 14 Tjarnargata, Reykjavik, Iceland. This anniversary is being held from June 26th to 30th, 1930.

Icelandic nurses in foreign countries desiring positions in the new State Hospital of Iceland, to be opened in Reykjavik in the autumn of 1930, are requested to send their applications to the Icelandic Nurses Association, from which further particulars may be obtained:—(Mrs. Sigridur Thorvaldsson, President of the Icelandic Nurses Association, 14 Tjarnargata, Reykjavik, Iceland.)

Great Empire Red Cross Conference

Many interesting features will characterise the forthcoming British Empire Red Cross Conference which is to take place in May in London, England, according to information now in the hands of the headquarters' officials of the Canadian Red Cross Society in Toronto.

The sessions of this unique gathering will be held in the historic St. James Palace, which is now so prominently before the eye of the world as the meeting place of the Disarmament Conference.

On May 20th its plenary session will be presided over by the Duke of York, while Princess Mary is scheduled to inspect the various V.A.D. detachments, present from many parts of the United Kingdom.

Invitations to send delegates to this Empire-wide conference of Red Cross workers have been issued by Brigadier-General H. B. Champain, of the British Red Cross Society, who has created a new precedent by asking attendance of representatives from all overseas parts of the Empire, large or small, and irrespective of whether they possess organised Red Cross Societies or not.

The agenda as foreshadowed by the tentative programme will be very broad as it will deal with not only Empire and national activities but with many international aspects of Red Cross work. Some of its proposed features include addresses from prominent health or educational authorities, demonstrations in London county council schools, an elaborate Junior Red Cross Empire Pageant, the possibilities of co-operative effort of Junior Red Cross with all other organisations of juveniles within the Empire, and the widest discussion of the international and imperial aspects of the Red Cross.

The Canadian Red Cross Society will send at least two official delegates to the Empire Conference, with several additional representatives who will be named at the next meeting of the Central Council.

TAKE CARE OF YOUR MACHINE

The human body like a great, complete machine weakens and slows with age and neglect. Age must come, but neglect may be cheated of its toll in body health through periodical physical inspection.

A person who has so much vitality as to lead him to defy the laws of health and to boast that he pays no price no matter how he lives, is likely to be the very one to exhaust his account of health prematurely.

The Flora Madeline Shaw Memorial Fund

A scholarship of $500 is offered, the first to be awarded in memory of Miss Flora Madeline Shaw, to Registered Nurses wishing to take a Post-Graduate Course at the School for Graduate Nurses, McGill University, Montreal. Graduates from this School, wishing to take advantage of a second year at the School, will be considered eligible, also Registered Nurses who have passed the matriculation examination.

Applications should be received before June 1st, 1930, and should be sent to:
Miss E. FRANCES UPTON, R.N., Convener of Committee,
Room 221, 1396 St. Catherine Street West, Montreal
(See Advertising Section, page 216)

Book Reviews

School Health Work in Cattaraugus County, by C. A. Greenleaf, M.D., Director of Cattaraugus County School Health Service.

A review of the demonstration which was set up in 1923 by the local County Board of Health, with the aid of appropriations from the County, a memorial fund, and from the State of New York.

The object of the demonstration is to develop a thorough and efficient county health service which would also serve as a demonstration in rural public health administration. Cattaraugus was the first county in New York State to develop a county-wide modern public health programme

The organisation of the health service, of which a very complete outline is given, meant an opportunity to test the value of those methods of public health administration which have been found effective in cities, as well as determining the possibility and feasibility of applying a public health programme in a rural county with a widely scattered population, to determine its cost, and so far as practicable to measure its value to the community.

The aim of the school health phase of the demonstration is to establish a fairly adequate school hygiene service. The details of this phase of the work are very fully explained. The results set forth are for the most part those of a tangible nature. The report does not discuss the ultimate benefits that the children of the County will undoubtedly derive from the school health service, nor does it attempt to consider any influence that the work may have, or may have had during the initial three years upon the morbidity and mortality rates of the community. To draw conclusions of too far-reaching a nature at the expiration of the first three years of the work would be unwarranted. Therefore, the report is merely a summary of those results which seem to the school health administrators to be the outstanding measurable accomplishments of this period.—Gertrude M. Hall, P.H.N., Normal School, Winnipeg.

Study Guide Test Book in Anatomy and Physiology, by Carolyn E. Gray, A.M. (Columbia University), R.N. Published by Macmillan Publishing House of Canada, Toronto. Based on Text Book of Anatomy and Physiology, by Diana C. Kimber and Carolyn E. Grey. Price $1.20.

This book has been compiled for the purpose of saving the instructor's time, and contains an exhaustive number of reviews for students. There are twenty-three chapters, and these are divided into one hundred and eighty-one exercises, containing questions which cover the subjects of Anatomy and Physiology completely. The rating is given with each exercise and can easily be compared with that made by the student. The answers required are very brief, in some cases just the writing of a word or number.

There are a number of diagrams with lines pointing to different parts. The student is to write in the proper name of the part indicated. Exercises of this kind will be very valuable in giving the student an intelligent idea of the part of the body which she is studying and by visualising, to fix it in the mind.

This book should be in every class room. It will be a great boon to the instructor, and very much lessen the work of preparation. —Olive A. MacKay, Superintendent, Miramichi Hospital, Newcastle, N.B.

BOOKS RECEIVED

Pediatric Nursing, by Gladys Sellew, R.N., Assistant to Dean, Illinois Training School for Nurses. Second edition, illustrated. Price $2.50.

Principles of Surgery for Nurses, by M. S. Woolf, B.Sc., M.R.C.S. Second edition, revised. Price $3.00.

A Text Book of Psychology for Nurses, by Maude B. Muse, R.N., A.M. Second edition, revised, illustrated. Price $2.50.

A Text-Book of Nursing Technique, by Irene V. Kelly, R.N. Second edition, revised, illustrated. Price $2.50.

The Technique of Nursing, by Minnie Goonow, R.N. Second edition, revised, illustrated. Price $2.50.

Obstetrics for Nurses, by Charles B. Reed, F.A.C.S., and Charlotte L. Gregory, R.N. M.D. Third edition, illustrated. Price $3.00.

Dermatology and Syphilology for Nurses, including Social Hygiene, by John H. Stokes, M.D. Illustrated. Price $2.50. Publishers of the foregoing books are McAinsh & Co. Ltd., Toronto, Ont.

Who's Who in the Nursing World, the Nursing Year-Book, 1930, for England, Compiled and edited by H. E. Smithers. Publishers, Professional Publications Ltd., 139 High Holborn, W.C. 1, London. Price 5 shillings.

News Notes

GENERAL MEETING, C.N.A.

The Programme Committee for the General Meeting, June 24 to 28, 1930, announce that Dr. G. M. Weir has consented to be present and give two addresses. Dr. Weir is already well known to the members of the Canadian Nurses Association for the splendid way in which he is directing the Survey on Nursing in Canada.

The visiting nurses are to be the guests of the Saskatchewan Registered Nurses Association at dinner on Tuesday evening, June 24th, at which representatives of the province and city will welcome the nurses to Saskatchewan and Regina. Dr. Weir will be the principal speaker at the dinner, when his subject will be "The Nurse and the Public".

An open meeting will be held on Wednesday evening, when Dr. Weir will deal with "Facts, Fictions and Opinions regarding Nursing Education".

At the same session the nurses will be delighted to learn that Miss Ethel I. Johns will address them; Miss Johns is to be the guest of the Canadian Nurses Association, and will also address a later session on Nursing Education, as well as participate in Round Table discussions.

The Public Health and Private Duty Sections are each arranging for speakers especially qualified to deal with their specific interests and problems. The Nursing Education Section is planning to have a demonstration in teaching, and all three sections are preparing for round tables. Also it is planned to have educational films for teaching purposes shown at an evening session.

Several questions of vital interest to the Canadian Nurses Association will receive attention, so that it is hoped all parts of the Dominion will be well represented.

The meeting is to be held in the Hotel Saskatchewan, where all visiting nurses may make reservation for accommodation at an early date.

The rates are: Single rooms, $4.50 to $5.50 per day; Double rooms, $8.00 to $9.00 per day. The latter are furnished with twin beds, and each room has a bath. Reservation should be made direct to the Manager, Hotel Saskatchewan, Regina, Sask.

Nurses are advised to use the Summer Tourist rates for travelling to Regina. These rates allow for various routings and carry stop-over privileges.

An invitation has been received from the American Nurses Association for Canadian nurses to attend the Biennial Meeting of the A.N.A., which is to be held in Milwaukee, June 9th to 16th, 1930. Meetings of the National League of Nursing Education and the National Organisation of Public Health Nursing will be held during the same week.

ALBERTA

Medicine Hat: The Medicine Hat Graduate Nurses Association held their annual meeting on February 4th. Mrs. D. M. Smith was elected president for the ensuing year. After the business meeting a delightful evening of contests with music and refreshments followed.

Miss Maud Davidson, of the Provincial Department of Health, is convalescing at the Y.W.C.A.

Calgary: On February 12th, 1930, the Calgary Association of Graduate Nurses held their annual dance in the Al Azhar Temple. The hostesses were Misses H. Ashe, S. MacDonald and B. J. Von Gruenigan. The dance under the convenership of Miss Grace Hill, was a most delightful event, some 300 guests being present.

BRITISH COLUMBIA

General Hospital, Vancouver: The regular monthly meeting of the Alumnae was held in the rotunda of the Nurses Home, on March 4th, Miss Olive Cotsworth presiding.

It was decided to have the next meeting a social one in honour of new members, and to welcome the graduating class. Ways and means of adding to the Sick Nurses' Benefit Fund were again discussed, and final arrangements were made for the annual reunion dinner and dance.

On March 7th, the annual Alumnae banquet took place at the Hotel Georgia. About seventy members were present. The usual happy greetings and brief visits with old friends in the lounge before all were gathered, the usual babel of voices, a short speech of welcome from the President, Miss Cotsworth, and another very happy one from the new Honorary President, Miss Fairley, and a programme including songs by one of the members, Miss A. J. Murray, made time pass very pleasantly and all too quickly. Dancing and cards followed and so prolonged another very successful gathering.

Miss Bessie Clark, a Vancouver General Hospital graduate, who for the last eight years has been in charge of the Vernon Jubilee Hospital, Vernon, B.C., has recently been appointed Superintendent of Nurses for the Royal Columbian Hospital, New Westminster, B.C., and will assume her new duties in the near future.

MANITOBA

Brandon: The monthly meeting of the Brandon Graduate Nurses Association was held at the home of Mrs. Napiers. Dr. Doyle, of the Industrial School, gave an address on "Nursing Needs in Unorganised Territory". At this meeting Mrs. A. O. Miller was presented with an etching previous to her departure for Winnipeg.

During Miss E. Smellie's recent visit to Brandon she was the guest of honour at a dinner given by the Graduate Nurses Association. Among those present was Miss E. Birtles, the first nurse to graduate from a Manitoba hospital, and the first hospital matron in Alberta. Following the dinner each of the members present gave a graphic account of her experiences since entering the nursing profession.

General Hospital, Winnipeg: Miss Dorothy Suhring (1928), has resigned from the staff of the Winnipeg General Hospital and has joined the staff at the City Hospital, Saskatoon, Sask. Other recent appointments are: Miss Ruby Johnson (1927), to the staff, Children's Hospital, Detroit, Mich., and Miss Helen Baggott (1927), to the X-ray Department, Winnipeg General Hospital.

Mrs. E. Sutcliffe (Elspeth Moffatt, 1921), has left for Halifax where she will reside in the future.

The sympathy of the Alumnae members is offered to Mrs. J. Olson (R. Thompson, 1919), in the death of her husband.

NEW BRUNSWICK

Saint John: At the January meeting of the Saint John Chapter of the New Brunswick Association of Registered Nurses, when Miss E. J. Mitchell (president) presided, it was decided that a life membership in the Saint John Council of Women be conferred on her. This life membership is being conferred as a tribute to Miss Mitchell and in order that the nurses may contribute to the Foundation Fund of the Council.

The meeting was well attended and at it a very interesting address was delivered by Dr. A. B. Walter on the subject of "Leukaemias." The address was followed with close attention and was much appreciated. After the general meeting there was a pleasant social hour and refreshments were served.

Saint Stephen: The regular meeting of the St. Stephen Chapter of the New Brunswick Association of Registered Nurses which was held on February 27th, was well attended. Miss Jessie Murray occupied the chair. After the regular business, delicious refreshments were served and a social hour was enjoyed.

Miss Mabel McMullen has returned from Edmunston where she has been professionally engaged.

The friends of Miss Alice Bishop are glad to know that she is recovering from a severe illness at her home in Perth.

Miss Eileen O'Brien is taking a much needed rest at her home in St. George.

Miss Helen Boane is visiting friends in New Jersey.

NOVA SCOTIA

Halifax: Miss Edith Fenton, Superintendent of Nurses, Dalhousie Health Clinic, Halifax, who was awarded a Travelling Fellowship by the Rockefeller Foundation, has spent the past six weeks observing and studying public health, first with the Department of Public Health Nursing, University of Toronto, and then at the following places in the United States: Department of Health, Detroit; Alabama State Board of Health, Montgomery; American Red Cross, Washington; Philadelphia General Hospital; Yale School of Nursing, New Haven; Providence City Hospital; Peter Bent Brigham Hospital, Boston; and East Harlem Nursing and Health Centre, where two weeks were spent.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario, in March, 1930, were 1388. One hundred and six more than in February, 1930.

Appointments

Misses Monica Thomas and Helen Derby (Oshawa General Hospital, 1929), to the staff, New Rochelle Hospital, New York.

Miss Gertrude Rowntree (Toronto Western Hospital, 1925), industrial nurse at the Toronto Kodak Co.

Misses Irene Edwards and Verda Brinston (Brockville General Hospital, 1929), to the staff of the Hospital at West Hudson, Kearny, New Jersey.

Miss Myrtle MacMillan, formerly superintendent of Public Hospital, Smiths Falls, Ont., has resigned and taken over the superintendency of the General Hospital, Glace Bay, N.S.

Miss Arlie Bisbee (Victoria Hospital, London, Ont., 1923), Supervisor, Lakeside Hospital, Cleveland.

District 1

Memorial Hospital St. Thomas: The Alumnae held its annual dance on January 8th, 400 attended, and $90.00 was realised for the Association funds.

Misses Mary Buchanan and Gertrude Trothen represented the Alumnae at the recent meeting of District No. 1 in Walkerville.

Miss Hazel Mann (1920), who is home on furlough, addressed the Alumnae at the first meeting of the year on her work as superintendent of a missionary hospital at Ilivilio, Philippine Islands; Miss Mann returns to her work this month.

District 3

General Hospital, Brantford: The Alumnae recently entertained the Florence Nightingale Chapter to a bridge and euchre. Dainty refreshments were served.

Miss Jessie Wilson, assistant superintendent, has sufficiently recovered from her recent illness to be back on duty.

Miss P. Robinson was married recently.

Miss M. Fasken, Kitchener, has returned to her duties as Public Health Nurse after spending the winter in California.

Miss K. Greensides has recovered sufficiently from her recent illness to be taken home from the Brantford General Hospital.

District 4

General Hospital, Hamilton: The bridge and dance, held by the Alumnae and the Medical Orchestra on February 5th, was very much enjoyed.

Dr. Deadman gave a very interesting illustrated lecture on Egypt at the January meeting, and Dr. A. Kelly at the February meeting told about vitamines, and the part they play in the development of healthy babies.

Miss Anna Coutts (1926), has returned to the City and is doing private duty.

DISTRICT 5

WESTERN HOSPITAL, TORONTO: Miss Helen Harvey (1920), has resumed duties with the Public Health Department in Toronto.

Mrs. Elizabeth Duff (1920), has left for a three months trip to Miami, Florida. Miss Ruth McLean (1926), is relieving for her.

A large attendance of members was present at the February meeting of the Alumnae. Lantern slides and a very interesting lecture on "Spinal Anaesthesia" was given by Dr. Willinsky.

GENERAL HOSPITAL, OSHAWA: The annual meeting of the Alumnae was held at the Nurses Residence on January 27th, 1930. During the year eight meetings were held with an average attendance of fourteen members.

The Alumnae is endeavouring to collect and set aside a certain sum to furnish and maintain a room in the Hospital for sick nurses.

The treasurer's report showed that the Association had a successful financial year.

The Graduate Nurses of the Oshawa General Hospital held their annual At Home, at the Genosha Hotel, February 7th, which was one of the most brilliant and successful social functions of the season.

GENERAL HOSPITAL, TORONTO: Myrtle Bruce (1926), and Claire McConnell (1928), motored to Florida and will spend some time there. Harriette Town (1929), is doing floor duty in a hospital on Long Island; Flora Smart (1925), has returned from South Porcupine Red Cross Hospital, and is now doing special duty nursing; Hilda McLellan, Mayreen Vick, and Helen Sirrs (1929), are nursing in Bermuda this winter; Margaret St. John (1925) has gone to the continent for a few months with a patient.

Miss Laura Lindsay (1928), has been appointed assistant treasurer to Miss McGeachie.

Miss Sadie Parnham (1925), has left for South America where she has accepted a post with the Imperial Oil Co.

DISTRICT 7

BROCKVILLE: Miss Anna Wright (Brockville General Hospital, 1929), is doing private duty nursing in Syracuse, N.Y.

QUEBEC

GENERAL HOSPITAL, MONTREAL: Miss Margaret Hume is convalescing at her home in Ottawa.

Misses Jean Whimbey and Grace Munro are in Bermuda, doing private duty nursing.

Miss E. M. McKee (1917), Superintendent of Brantford General Hospital, paid the Hospital a flying visit recently.

Mrs. Herbert MacDougall (Mary J. Whitehead, 1917) has taken up residence in Montreal.

Miss Catherine Kearns (1929) has charge of a Medical Ward in the Evanston Hospital, Evanston, Ill.

Miss J. Webster, Night Superintendent, and Miss Strumm, First Assistant, have both been patients in hospital recently and are now convalescent. Others who have been ill in hospital recently are the Misses Ives, Cowen, McCallum.

The sympathy of the Association is extended to Mrs. Patrick (Miss De Kalb, 1899), in the death of her husband, Dr. Patrick.

Dr. Hodges gave a most interesting lecture with slides on the different uses of the Bronchoscope, to the Alumnae Association at their February meeting.

Miss Elizabeth Odell, Superintendent, Evanston Hospital, Evanston, Ill., has been spending a short holiday at her home in Montreal.

SHERBROOKE HOSPITAL, SHERBROOKE: The Graduation Exercises of the 1930 class took place on February 28th at the nurses' home. The nurses graduating were: Misses Georgia Crawford, Florence Lafond, Dorothy McKee, Rita Ross, Blanche Westover, Pearl Paige, Irene MacLeod and Mrs. Norah Blake.

Special awards were: President's Prize, to the student who had shown the most loyalty and upheld the standard of the Hospital and Training School, also Dr. Lynch's prize for surgery, Miss Dorothy McKee.

Prize for best practical work in the wards, presented by Dr. Gordon Hume, to Miss Georgia Crawford.

Prize for highest marks, presented by Dr. Winders, to Miss Blanche Westover.

Prize for general proficiency, to Miss Dorothy Seiverights.

Prior to the Graduation the nurses were given a dinner followed by a very enjoyable evening at the theatre. After the Graduation a dinner was given at the Hospital and a dance at the nurses' home.

The sympathy of the members of the Association is extended to Miss Nora Arguin in the death of her mother.

Mr. and Mrs. W. L. Reford Stewart, of Sherbrooke, are travelling in England, Scotland and the continent.

Miss Evelyn Warren returned from a trip to Boston and is now doing private nursing.

Miss Jean Fenton has returned from a short visit to her home in St. John, N.B.

The annual meeting of the Alumnae took the form of a turkey dinner, which was enjoyed by all present. After the dinner routine business was transacted, also election of officers.

SASKATCHEWAN

GENERAL HOSPITAL, REGINA: Miss Elizabeth Smellie, of Ottawa, addressed the Registered Nurses last week; she dealt with the programme of nursing that the Victorian Order is carrying out, also outlining a few events in her own professional career. After her talk, which was enjoyed very much, lunch was served and a pleasant social hour spent together.

Word has been received from Mrs. T. Armstrong, formerly Miss Alice Blacklock (1927), that she has enjoyed the winter in California. It is hoped she will return to Canada soon.

Mrs. Alex. Wills (Charlotte Shank, 1925), with her young son Donald, of Hawarden, Sask., has been a visitor in Regina for the past few weeks.

Mrs. Grant Robertson (Bobbie Haight, 1925), with her husband and young son, has left Regina and is now residing in Saskatoon.

Miss Mabel Baker (1927), who, prior to her illness, was in the operating room, is reported to be making satisfactory progress towards recovery. Miss Baker has been a patient at Fort Sanatorium since the first of this year. The members of the Alumnae wish her a speedy recovery.

Grey Nuns Hospital, Regina: A meeting of the Alumnae was held on February 13th, when arrangements were made for a dance to be given by the Alumnae to the graduating class of 1930 at the Sacred Heart Hall. The design for the Alumnae pin was also discussed and chosen.

The best wishes of the Alumnae members were offered to Mrs. P. Smith on the occasion of her marriage at a shower given at the home of Mrs. Grant Lewis on February 28th. Refreshments were served and a pleasant evening spent.

On March 3rd, the dance given by the members of the Alumnae to the graduating class of 1930 was held at the Sacred Heart Hall. There was a large attendance, and the event was a great success and thoroughly enjoyed by all present. Mrs. Fyfe and Miss Anderson received the guests.

St. Paul's Hospital, Saskatoon: The Alumnae recently held a theatre party at the Capitol, later going to the Coffee Shoppe for lunch; everyone voted a very enjoyable time.

The Rev. Sister Fennell and the Rev. Sister Weeks paid a short visit to Edmonton in January.

Sister Longton is having a month's rest in Montreal.

The 1930 graduating class have recently written their registration examinations.

Miss Esther Hughes (1923) visited Saskatoon recently on her way back to Vancouver.

C.A.M.N.S.

British Columbia: There passed away at Shaughnessy Heights Hospital, Vancouver, on February 14th, in her thirty-seventh year, Dorothy Beryl Morison, beloved wife of Charles Keith Morison. The late Mrs. Morison (nee Moss) was born and educated in Victoria. She later trained as a nurse in the Montreal General Hospital. Graduating from there early in 1917, she went overseas, where she served as a nursing sister with the C.A.M.C. in England and France, notably at Doullens during the hectic days of the German drive in the spring of 1918.

Married in 1921, Mr. and Mrs. Morison went to live in California, returning to Victoria in 1926. Mrs. Morison was in very delicate health for several years, but only went to Shaughnessy Hospital a few months ago for special treatment.

The funeral service took place on Monday, February 17th, in Vancouver. The pall bearers were all veterans of the great war, who thus paid their last tribute of respect to a nursing sister.

Victoria: The overseas Nursing Sisters Club extend their sympathy to N.S. L. Gregory-Allen in the death, after a long illness, of her mother.

Mrs. Joseph Wark (nee Marion Park, Winnipeg General Hospital, 1904) is visiting in Victoria, the guest of Miss Edith Franks and Mrs. R. Coombes.

Manitoba: The sixth annual meeting of the Nursing Sisters' Club was held at the Nurses Registry, with the President, Miss M. McGillvray, in the chair. The following officers were elected for the ensuing year: President, Miss M. McGillvray; Vice-President, Mrs. C. W. Davidson; Convener, Memorial Committee, Miss G. Billyard; Convener, Sick Visiting Committee, Miss E. Bayliss; Convener, Social Committee, Miss K. McLearn; Convener, Publicity Committee, Miss Jane Roberts; extra members, Mrs. Morrison, Miss Meehan.

Miss Letellier, the retiring treasurer, was tendered a vote of thanks for her services in that capacity since the formation of the Club, and was presented with a bouquet of russet roses.

Refreshments were served at the close of the meeting.

A very delightful event of Saturday, March 1st, was the silver tea held at the home of Mrs. C. W. Davidson, for members and friends of the Nursing Sisters' Club.

The guests were received by the hostess together with the President, Miss M. McGillvray and Miss K. McLearn of the Social Committee.

Miss J. MacDonald and Miss E. Bayliss have been taken on the staff at Deer Lodge Hospital.

Friends of Mrs. U. Scott (nee Ursala Peyton) were shocked to hear of her sudden death at the Winnipeg General Hospital on February 22nd, 1930.

Mr. and Mrs. B. E. Hull (nee Vera Strange), have moved to Brandon, where they will reside. Mrs. Hull was an active worker in the Nursing Sisters' Club while in the City.

Miss K. McLearn, Superintendent, Shriner's Hospital, has returned from a visit to St. Louis, Mo., where she attended the Shriners Hospital convention.

The many friends of Miss Atterill, of the staff of Child Hygiene, City, will be pleased to learn that she has recovered from her recent illness.

Mrs. R. C. Sanderson (nee N/S. McLennan), who has been living at The Pas for some time, has returned to the City.

Miss O. Garland, Matron, Deer Lodge Hospital, who has been on a two months visit to friends in California has returned to the City.

VICTORIAN ORDER OF NURSES

During the past six weeks Miss Elizabeth Smellie, Chief Superintendent of the Victorian Order of Nurses for Canada, has been visiting the western districts of the Order. Miss Smellie, at the request of the Association of Canadian Clubs, has addressed a number of Canadian Clubs throughout the West, on the subject, "A Nurse Looks at Life."

Since recent reorganisation the Central Office staff of the Victorian Order of Nurses for Canada now comprises the Chief Superintendent, Miss Elizabeth L. Smellie; two assistants, Miss Maude Hall and Miss D. M. Percy, and three field supervisors, Miss Nan McMann, Western Supervisor; Miss Ethel Cryderman, Central Supervisor; and Miss Winnifred Dawson, Eastern Supervisor.

The eastern and western supervisors of the Order now reside in their own territory, coming into the Central Office at Ottawa only once or twice a year.

Miss Winnifred Dawson, the most recent appointment to the staff, replaces Miss Mary Stevenson, who resigned early in the autumn to become Assistant Superintendent of the Local Association of Greater Montreal. Miss Stevenson has been attached to Central Office of the Order for many years, and local V.O.N. associations and nurses owe much to her sound knowledge and wide experience as well as to her sympathetic handling of their problems.

In November the resignation of Miss Kate S. Cowan was accepted with regret and later in the same month Miss Maude Hall, latterly attached to the staff of the Public Health Clinic at Dalhousie University, Halifax, was appointed as assistant superintendent.

With decentralisation at last a "fait accompli" and Central Office staff up to strength, the Victorian Order is anticipating with reasonable hope a year characterised by progress and growth along sound lines.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

DAVIES—Recently, at Regina, to Mr. and Mrs. W. Davies (Grey Nuns Hospital, Regina), a son.

DIXON—In February, at Utica, New York, to Dr. and Mrs. W. Dixon (Anne McLellan, Toronto General Hospital, 1922), a daughter.

EMMONS—On March 4th, 1930, at Vancouver, to Mr. and Mrs. Edward Emmons (Blanche Babbitt, Vancouver General Hospital, 1919), twin daughters, Jean and Joan.

FRASER—On February 26th, 1930, to Dr. and Mrs. Roy Fraser (Hawkins, Winnipeg General Hospital, 1925), a daughter.

MACKIE—On February 12th, 1930, at Saskatoon, to Mr. and Mrs. R. Mackie (Susan Scott, Saskatoon City Hospital, 1922), a son (Keith Scott).

MILNE—On February 17th, 1930, at Calgary, Alta., to Dr. and Mrs. J. D. Milne (Esther Douglas, Calgary General Hospital, 1926), a daughter.

MURRAY—On February 12th, 1930, at Toronto, to Mr. and Mrs. G. M. Murray (Marion Fenson, Toronto General Hospital, 1923), a daughter.

McMURTRY—On Fenruary 18th, 1930, at Montreal, to Mr. and Mrs. Alex. O. McMurtry (Isabella Stratby, Montreal General Hospital, 1914), a daughter.

ROSS—On January 10th, 1930, at Brockville General Hospital, to Mr. and Mrs. Donald Ross (Margaret Kerr, 1924), a daughter.

THORNE—On January 3rd, 1930, at Lynn, Mass., to Mr. and Mrs. Robert Thorne (Marguerite Belding, General Public Hospital, Saint John, N.B.), twins, boy and girl (Ruth Ann and Gordon Samuel).

WRINCH—On February 7th, 1930, at Royal Victoria Hospital, Montreal, to Mr. and Mrs. Sidney Wrinch (Jean Tier, Toronto General Hospital, 1925), a daughter.

MARRIAGES

ANDERSON—SMITH—On February 12th, 1930, at Hamilton, Marion K. Smith (Hamilton General Hospital, 1927), to Beverley Anderson, Simcoe, Ont.

ARNOLD—WALLACE—On November 2nd, 1929, at Strathroy, Ont., Frances A. Wallace (Homewood Sanatorium, Guelph, 1924) to Sherman M. Arnold, of D'Arcy, Sask.

BERDAN—SAGE—On February 6th, 1930, Estella Sage (Memorial Hospital, St. Thomas, 1927) to Clarence Berdan, of Talbotville.

BLYTHE—JOHNSON—On February 4th, 1930, at Saskatoon, L. Johnson (St. Paul's Hospital, 1926) to G. Blythe.

ELLIOTT—LACHEUR—On February 25th, 1930, Grace Lacheur (Saskatoon City Hospital, 1926) to Harold Elliott, of Carberry, Man. At home Belmore Apts., Saskatoon, Sask.

FINAN—STEWART—On March 3rd, 1930, Marjorie Isobel Stewart (Regina General Hospital, 1925) to Robert Finan, of Chicago, Ill.

HOGG—MOORE—On February 12th, 1930, at Ottawa, Edna G. Moore (Montreal General Hospital, 1928) to Charles K. Hogg, Westmount, P.Q.

IRWIN-SMITH—On February 22nd, 1930, in New York City, Winnifred Smith (Toronto General Hospital, 1921), to Frank Irwin.

JACKSON—FREZELL—On January 30th, 1930, Naomi Lillian Frezell (Victoria Hospital, London, 1929) to M. Alexander Jackson, of Port Huron, Mich.

MADILL — REYNOLDS — On February 20th, 1930, Dora Rosamund Reynolds (Saskatoon City Hospital, 1925) to Harry A. Madill, of Saskatoon.

McGUGAN—BIRT—On December 30th, 1929, at St. Thomas, Gwendolyn Frances Birt (Memorial Hospital, St. Thomas, 1922) to Alexander McGugan, of St. Thomas.

PALMER—SHARPE—On February 3rd, 1930, at Lakewood, Ohio, Mary Ellen Sharpe (Montreal General Hospital) to Hugh Albert Palmer.

ROBERTSON—McMULLEN—On January 28th, 1930, at Vancouver, Jean McMullen (Winnipeg General Hospital, 1927), to Dr. John Robertson.

RUNDLE—INNIS—Recently at Vancouver, B.C., Hattie B. Innis (Vancouver General Hospital, 1918) to William A. Rundle, of Vancouver, B.C.

RUSSELL — BAKER — On February 8th, 1930, Irene Baker (Saskatoon City Hospital, 1927) to Harold Russell, of Edmonton, Alta.

SMALE—HARDY—Recently, at London, Ont., Gladys Hardy (Memorial Hospital. St. Thomas, 1927) to John Smale, of St. Thomas.

STEVENS—HARRIS—Recently, at London, Ont., Louise (Queenie) Harris (Victoria Hospital, London, 1929) to Dr. Eugene Stevens. Dr. and Mrs. Stevens sailed from Vancouver on February 15th, en route for Taikoku, Formosa, where Dr. Stevens will join the staff of the McKay Memorial Hospital.

WAIT — MEDDINS — On January 14th, 1930, at Aberdeen, Mary Constance Meddins (St. Paul's Hospital, Saskatoon, 1920) to Dr. Frederick E. Wait. At home, 112 11th Street, Nutana, Sask.

DEATHS

JOHNSON—On February 19th, 1930, at Tucson, Arizona, Margaret Johnson (St. Joseph's Hospital, Victoria, 1928).

JOHNSON—On March 8th, 1930, at Deloraine, Man., Muriel Johnson (Winnipeg General Hospital, 1929), accidentally killed.

MARDELL—On January 15th, 1930, at San Francisco, Iris Morton Mardell (St. Jospeh's Hospital, Victoria, 1927).

MORISON — On February 14th, 1930, at Vancouver, B.C., Mrs. Charles K. Morison (Beryl Moss, Montreal General Hospital, 1917).

REGISTRATION of NURSES

Province of Ontario

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held in May.

Application forms, information regarding subjects of examination, and general information relating thereto may be had upon written application to

MISS A. M. MUNN, Reg.N.,
Parliament Bldgs., Toronto

EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA are to take place Wednesday and Thursday, May 14th and 15th, 1930. Candidates are requested to send in their application forms, accompanied by diploma and initial registration fee of $10.00 before April 14th, 1930, to

L. F. FRASER, Registrar,
The Registered Nurses Association of Nova Scotia,
Eastern Trust Bldg., Halifax, N.S.

THE CANADIAN NURSE

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Editor and Business Manager: JEAN S. WILSON, Reg.N.

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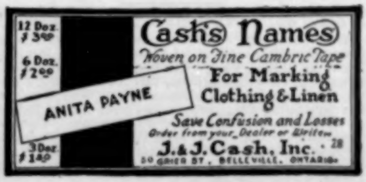
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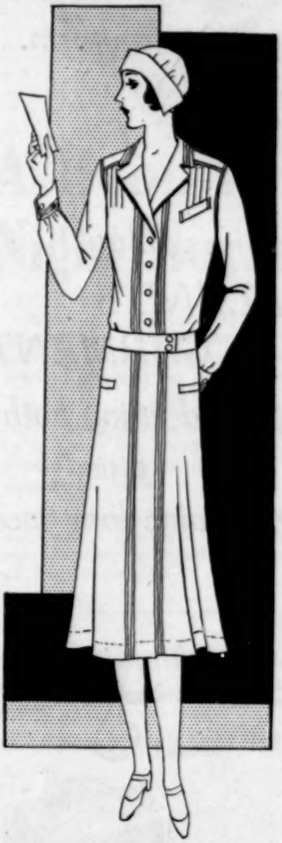

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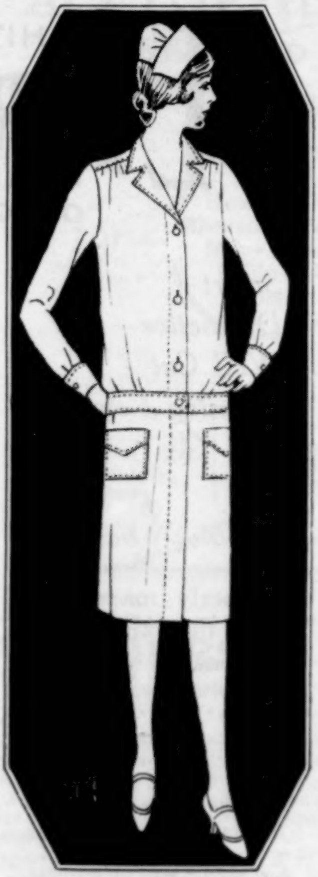

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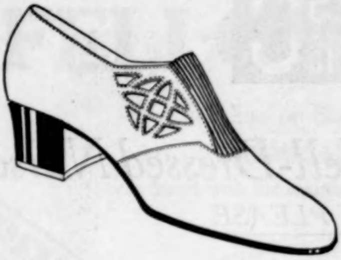

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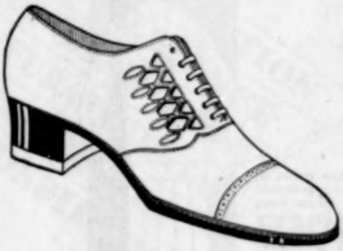

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